Faith Baptist Schools
7644 Farralone Avenue
Canoga Park, CA 91304

Authorization to Treat a Minor

Student's Name _____ Birthdate _____

Father's Name _____ Mother's Name _____

Father's Work Phone _____ Father's Cell Phone _____

Mother's Work Phone _____ Mother's Cell Phone _____

Home Address _____

City/State/Zip _____ Home Phone _____

Last Diptheria Tetanus Booster ____/____/____ Allergies to Drugs and Foods _____

Any Special Medications or Pertinent Information _____

Family Physician _____

Address _____ City_____ Zip Code _____

Insurance Company _____ Policy No. _____

I (we) the undersigned parent(s), or legal guardian, of _____ , a minor, authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medical Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the state of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required and is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that all effort shall be made to contact the undersigned prior to rendering treatments to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provisions of section 25.8 of the Civil Code of California.

_____ _____

SIGNATURE OF FATHER, MOTHER, OR LEGAL GUARDIAN DATE