GLENDALE COMMUNITY COLLEGE
CHILD DEVELOPMENT LABORATORY SCHOOL

AUTHORIZATION TO TREAT A MINOR
EMERGENCY INFORMATION

I/We the undersigned parents(s) or legal guardian of_____, a minor, do hereby authorize the Staff of the Glendale Community College Child Development Center to 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 Medicine 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 but is given to provide authority and power to render care which the aforementioned physician in the exercise of this best judgement may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment 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. It is understood that the resulting expenses will be the responsibility of the parent(s) or legal guardians or participant(s).

List any restrictions_____

_____
(Signature of Parent or Legal Guardian) (Date)

_____
(Address)

This consent shall remain effective as long as the child is enrolled in the Child Development Center.

Birth date _____ Date of last DPT booster_____

Allergies to drugs or foods _____

Any special medications or pertinent information _____
_____
_____

Contact info where parents (legal guardians) may be reached:

1._(name)_____

Home number:		Cellular:	
Work number:		Email:	

2._(name)_____

Home number:		Cellular:	
Work number:		Email:	

Family Physician_____ Phone _____

Child's Dentist_____ Phone_____

Insurance Company _____ Policy No._____ Group No._____