

**GLENDALE COMMUNITY COLLEGE  
PARENT SUPPORT CENTER  
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 Parent Support 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 judgment 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 Parent Support Center.

Birth date \_\_\_\_\_ Date of last DPT booster \_\_\_\_\_

Allergies to drugs or foods \_\_\_\_\_

Any special medications or pertinent information \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephones where parents (legal guardians) may be reached:

1. \_\_\_\_\_

\_\_\_\_\_  
Home

\_\_\_\_\_  
Work

\_\_\_\_\_  
Cellular

\_\_\_\_\_  
Beeper

2. \_\_\_\_\_

\_\_\_\_\_  
Home

\_\_\_\_\_  
Work

\_\_\_\_\_  
Cellular

\_\_\_\_\_  
Beeper

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

PSC Form 3/03