

SEBASTOPOL UNION SCHOOL DISTRICT  
PARENT AUTHORIZATION FOR MEDICAL TREATMENT  
(Confidential Information)

Student's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Message Number: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Male [ ] Female [ ]

Doctor's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Health Insurance: \_\_\_\_\_ Membership #: \_\_\_\_\_

Any known allergies: \_\_\_\_\_

Parent/Guardian's Name (print): \_\_\_\_\_

If an emergency, if parents or guardian cannot be reached, contact:

Name/Relationship	Phone
-------------------	-------

Name/Relationship	Phone
-------------------	-------

In the event of an emergency, (I)(We), the undersigned, parent/guardian of \_\_\_\_\_,

do hereby authorize the principal or designee, as agent for the undersigned, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act, whether such a diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization shall remain effective until \_\_\_\_\_, 20\_\_\_\_, unless sooner revoked in writing delivered to said agent(s).

Parent/Guardian Signature	Date
---------------------------	------