

CONCORDIA LUTHERAN SCHOOL

SCHOOL YEAR 2008-09

AUTHORIZATION OF CONSENT FOR THE TREATMENT OF A MINOR

Student name _____ Date of birth _____ Grade _____

Home phone: (_____) _____

Father – work phone: (_____) _____ (ext. _____)

Mother – work phone: (_____) _____ (ext. _____)

Emergency phone: (_____) _____ (ext. _____)

(In case parents cannot be reached)

Does student have any allergies? [] Yes [] No

If yes, please explain: _____

Date of last tetanus toxoid immunization: _____

Medical insurance carrier: _____ Group/Policy #: _____

Doctor's name: _____ Phone: (_____) _____

Any other pertinent information? _____

I, the undersigned parent/guardian of the minor child named above, do hereby authorize CONCORDIA LUTHERAN SCHOOL, as agent(s) 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 rendered under the general or specific supervision of any physician and/or surgeon licensed under the Medical Practice Act. 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 on the part of 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/her best judgment, may deem advisable. This authorization is given pursuant to the provisions of Section 6910 of the Family Code of the State of California and shall remain in effect through August 31, 2009.

Signature of Parent/Guardian: _____ Date: _____