AUTHORIZATION OF CONSENT FOR TREATMENT OF A MINOR

(I/We), the undersigned parent(s)/guardian(s) having legal custody/legal guardianship of _____, a minor, do hereby authorize Santa Barbara Unified School District as agent for the undersigned to consent to any x-ray, examination, anesthesia, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered and under the general care of a special supervisor of, any physical surgeon licensed under the Provisions of the Medicine Practice Act on the Medical Staff of any hospital, whether such 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 given to provide authority to power on the aforesaid agent to give specific consent to any or all such diagnosis, treatment, or hospital care which a physician, meeting the requirements of this authorization, may, in the exercise of his/her best judgement, deem advisable.

The authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

(I/We) hereby authorize any hospital, which has provided treatment to the above named minor pursuant to the provisions of Section 25.8 of the Civil Code of California to surrender physical custody of such minor to my above named agent upon the completion of treatment. This authorization is given pursuant to Section 128 of the Health and safety Code of California.

This authorization shall remain effective until **June 3, 2021** unless sooner revoked in writing delivered to agent.

☐ YES ☐ NO The team physician, trainer, and /or coach may apply first aid treatment until the family doctor, hospital, or paramedic can be reached.
☐ YES ☐ NO My consent is given to the team trainer in conjunction with the team physician, to render treatment of appropriate sports injuries utilizing appropriate procedures/modalities.
☐ YES ☐ NO My consent is given for coaches, traineeer, and/or team physician to use their own judgement in securing medical aid and ambulance service in case of an emergency if the parent(s)/guardian(s) cannot be reached..

PARENT/GUARDIAN NAME :_____

PARENT/GUARDIAN SIGNATURE :_____

RELATIONSHIP: _____ DATE: _____

EMERGENCY FORM
Parental Endorsement for the Care of a Minor

Student Name:		**Date of Birth:**		**Age**	
Address		**City:**		**Zip**	
		Insurance Company's Name		**Policy/Group #:**	

IN CASE OF AN EMERGENCY CONTACT:

Parent Name: Mother/Father		**Phone: Cell/ Home/Work**	( )	( )	( )
Parent Name: Mother/Father		**Phone: Cell/ Home/Work**	( )	( )	( )
Other Contact: Relation		**Phone: Cell/ Home/Work**	( )	( )	( )

Physician (Family)		**Phone:**	
Physician(Orthopedic)		**Phone:**	

Health History: Please fill complete ALL boxes, if none-write none.

Known Allergies		**Last Tetanus**		**Current Medications**	

Corrective Lenses	Glasses Contacts None	**Asthma**	Yes No	**Kidney Injuries**	Yes No	**Head Injuries**	Yes No	**Diabetes**	Yes No

Heart Conditions	Yes No	**Heat Stroke**	Yes No	**Other. Please explain**	