COTATI-ROHNERT PARK UNIFIED SCHOOL DISTRICT

PARENT AUTHORIZATION FOR MEDICAL TREATMENT

(Confidential Information)

Student's Name____ Grade ____________________

Address ____

Birthdate ______________ ☐ M ☐ F Telephone Number______________________________

Message Phone________________________________

Doctor's Name _______________________________________ Phone __________________________

Name of Health Insurance ___________________________________ Policy # __________________

Any known allergies ____

Father, Mother or Guardian's Name(s) (*please print*) ____

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In the event of an emergency, if parents or guardian cannot be reached, please contact:

Contact #1 ____Telephone _______________________
Name

Contact #2 ____Telephone _______________________
Name

(I) (We), the undersigned, parent(s) of _________________________________, a minor, 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 given 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 *Name* *Date*