# ASC Training Center
# Permission to treat a minor

Family Name: _____

I, the undersigned parent/legal guardian of, _____ minor(s), do hereby authorize and consent to any X-ray examination, MRI 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 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 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 his 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 6550 of the Family Code of California.

Signature: _____Date:_____ (***circle)*** Mother, Father, Legal, Guardian

In the boxes below list ALL medical information including allergies to food or medicine, asthma, diabetes, seizure disorders, special physical conditions, dietary and medications for each child. Use the back and include attachments if necessary:

| Childs name and age: | Childs name and age: |
|---|---|
| | |

**EMERGENCY CONTACT INFORMATION:**

Family's home phone number _____

Father's Work Phone _____ Father's Cell _____

Mother's Work Phone _____ Mother's Cell _____

**Emergency Contact if parents can't be reached** _____

Phone: _____ Cell _____

**Family's Insurance Co.** _____Policy#:_____

Family Physician(s): _____Phone Number(s): _____