

SPORT: \_\_\_\_\_  
LAST NAME: \_\_\_\_\_  
FIRST NAME: \_\_\_\_\_  
PHYS EXP: \_\_\_\_\_

### SRVUSD Emergency Authorization

**MUST COMPLETE THIS FORM FOR EACH SPORT THE STUDENT PARTICIPATES IN DURING THE SCHOOL YEAR**

#### Authorization to Treat a Minor

I (we) the undersigned Parent, parents or legal guardian of \_\_\_\_\_ a minor, do hereby authorize consent to any x-ray 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 Medical Practice Act or Dentist licensed under the provisions of the Dental Practice Act and on the staff of 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 advanced of any specific 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 this best judgment may deem advisable. It is understood that effort shall be made to contract 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 Sec. 25.8 of the Civil Code of Ca.

List of restrictions: \_\_\_\_\_

\_\_\_\_\_  
Date signature of Father, Mother or Legal Guardian

\_\_\_\_\_  
Address City State Zip

Birthdate \_\_\_\_\_ Last Tetanus Toxoid Booster \_\_\_\_\_

Allergies to  
Drugs or foods \_\_\_\_\_

Any special medications  
or pertinent info. \_\_\_\_\_

Telephones where parents may be reached:

\_\_\_\_\_  
Father Cell Home Business

\_\_\_\_\_  
Mother Cell Home Business

Family Physician \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_