AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

(I) (We), the undersigned parent(s)/guardian(s) of _____, a minor, do hereby authorize the Regents' Overnight Host Program, the University of California, Berkeley Health Services or attending medical personnel as agent(s) for the undersigned to consent to any X-ray examinations, anesthetic, medical or surgical diagnosis or treatment, or hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and/or surgeon licensed under the provisions of the Medical Practices Act, California Business and Professions Code §2000 et. seq.; or any X-ray examination, anesthetic, dental or surgical diagnosis or treatment, or hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any dentist licensed under the provisions of the Dental Practices Act, California Business and Professions Code §1600 et. seq.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care 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 aforementioned physician or dentist, in the exercise of his/her best judgment, may deem advisable. This authorization is given pursuant to the provisions of California Family Code §6910.

(I) (We) hereby authorize any hospital, which has provided treatment to the above-named minor pursuant to the provisions of California Family Code §6910, to surrender physical custody of such minor to (my) (our) above-named agent(s) upon the completion of treatment. This authorization is given pursuant to California Health and Safety Code §1283.

These authorizations shall remain effective until _____, 20___, unless sooner revoked in writing delivered to said agent(s).

_____ Signed: _____

Date of Signature Parent/Guardian

Address: _____

City: _____ State:_____

Phone No.: Home (____) _____

Work (____) _____Cell (____) _____

Emergency Information

IN CASE OF EMERGENCY NOTIFY: _____

Address _____ City _____State___ Zip _____

Phone: **Home** (____) _____ **Work** (____) _____ **Cell** (____) _____

IF DIFFERENT THAN ABOVE COMPLETE:

Father's Name _____

Address _____ City _____State___ Zip _____

Phone: **Home** (____) _____ **Work** (____) _____ **Cell** (____) _____

Mother's Name _____

Address _____ City _____State___ Zip _____

Phone: **Home** (____) _____ **Work** (____) _____ **Cell** (____) _____

MINOR'S PHYSICIAN

Name _____

Address _____ City _____State___ Zip _____

Telephone Number (_____) _____

Name of Medical Insurance Provider*_____

Policy # _____ Expiration Date _____

***Attach a copy of your medical card**

If your son or daughter has any allergies, medical problems or is taking medication that would be important for us to be aware of, please indicate here:_____
_____
_____