



I, \_\_\_\_\_, am the parent or legal guardian of \_\_\_\_\_,  
Name of parent or guardian Name of minor

hereinafter, "my child", who was born on \_\_\_\_/\_\_\_\_/\_\_\_\_\_. My child is attending and participating in activities at \_\_\_\_\_ (hereinafter, "camp," "church," "school," etc.), located at \_\_\_\_\_  
Name of organization

\_\_\_\_\_ in the city of \_\_\_\_\_, county of \_\_\_\_\_,  
Address

and state of \_\_\_\_\_, beginning on the day of \_\_\_\_\_.

I hereby authorize the \_\_\_\_\_ and his/her officers, agents,  
Supervisor / Pastor / Director

servants, or employees who are 18 years of age or older, who supervise the activities at this \_\_\_\_\_ into whose care my child has been entrusted, to consent to medical care  
Camp / Church

or dental care, or both, for my child under Sections 6901, 6902, and 6910 of the California Family Code. The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act for my child.

I further authorize the \_\_\_\_\_ and his/her officers, agents, servants, or  
Supervisor / Pastor / Director  
employees who are 18 years of age or older, who supervise the activities at the \_\_\_\_\_  
Camp / Church

to receive physical custody of my child, under Section 1283 (a) of the California Health and Safety Code, upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to the \_\_\_\_\_ and his/her officers, agents, servants,  
Supervisor / Pastor / Director

or employees who are 18 years of age or older who supervise the activities at this \_\_\_\_\_.  
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It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the supervisor and his/her authorized designee, in the exercise his/her best judgment on what is advisable for my child's care, upon advice of such physician, dentist, and surgeon.

Dated \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_  
Signature of parent or legal guardian



**Additional information**

\_\_\_\_\_  
Parent / Guardian Relationship to minor

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

\_\_\_\_\_  
Home phone Work phone Cell phone

\_\_\_\_\_  
Medical / Health Insurance Company Insurance Policy No. Doctor's phone

\_\_\_\_\_  
In case of emergency, notify parent or guardian Emergency phone Relationship to minor

\_\_\_\_\_  
Allergies / Allergic reaction of my child

\_\_\_\_\_  
Medicine being taken by my child

\_\_\_\_\_  
Other information regarding my child's health that a doctor should know