



# Fremont Baseball Incorporated

P.O. Box 1399 Fremont, California 94538 (510)-490-8189

*www.fremontbaseball.org*



## Authorization to Treat a Minor

I (we) the undersigned parent, parents, or legal guardian of \_\_\_\_\_, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical, or surgery 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 provisions of the Dental Practice Act and on the staff of any acute hospital holding a current license to operate a hospital from the State of California Department of Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but it is given to provide authority and power to render care, which the aforementioned physician in the exercise of his/her 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 25.8 of the Civil Code of California.

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

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

This consent shall remain until effect until \_\_\_\_\_ . (Enter Date)

Birth date: \_\_\_\_\_ Last Known Tetanus Toxoid Booster: \_\_\_\_\_

Allergies to Drugs or Foods: \_\_\_\_\_

Any special Medications or Pertinent information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### Telephone Numbers where parents can be reached:

Mother Home: \_\_\_\_\_ Work: \_\_\_\_\_ Pager/Cell: \_\_\_\_\_

Father Home: \_\_\_\_\_ Work: \_\_\_\_\_ Pager/Cell: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_