



Authorization of Consent to Treatment of a Minor

In the event that your student is injured while at school we prefer to take him to his own family doctor rather than a stranger. Under all circumstances we attempt to contact the parent and notify them of the injury and seek their advice and consent for medical treatment. It is not uncommon, however, that a student is injured and for one reason or another the parents are just not available by phone. Sometimes they are out shopping or have been sent on an errand for their employer. This makes it awkward since doctors will not perform medical practice on a minor without the consent of the parents.

Just in case any of this should happen to you, we would like to place in our files the following blanket authorization. Then, if we are unable to contact you we can still take your student to his doctor and have an injury treated. If your doctor is not available or if the injury prohibits a long ride to his office, this authorization enables us to take him to the closest licensed physician. We covet your cooperation. Please enclose separate authorization forms for each child enrolled.

Please complete this form in duplicate. If we have to use one, it may be necessary for you to fill out an additional copy since most doctors prefer to keep it in their files after use.



(I) (We), the undersigned, parent(s) or guardian(s) of _____, a minor, do hereby authorize Lutheran High School of San Diego, California as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the provisions of the Medical Practice Act by the medical staff of a licensed hospital whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid agents(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California and after a reasonable attempt has been made to contact parents and /or guardian.

This authorization shall remain effective until June _____, _____, unless sooner revoked in writing delivered to said agent(s).

DATE: _____

FATHER: _____
Signature

MOTHER: _____
Signature

Last Tetanus Shot: _____

LEGAL GUARDIAN: _____
Signature