

**AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR**

Student's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Birthdate) \_\_\_\_\_

We, the undersigned parents and/or guardian(s) of the above minor, have entrusted such minor into the care of:

\_\_\_\_\_ for the purpose of taking an educational field trip  
from Chaffey Joint Union High School District to \_\_\_\_\_ from \_\_\_\_\_, 19 \_\_\_\_\_  
and returning \_\_\_\_\_, 19 \_\_\_\_\_.

In such connection, we authorize such caring adult(s) to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to such minor under the general or special supervision, and on the advice of, a physician and/or surgeon licensed under the provisions of the Medicine Practice Act, or, if in another country or state, under the provisions of law in that country or state, governing the practice of medicine; or to consent to any X-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered to such minor by a dentist licensed under the provisions of the Dental Practice Act, or, if in another state or country, under the provisions of the law in that state or country governing the practice of medicine.

Whether on any occasion such consent is rendered to any such medical or dental attention, it is to be considered within the above provisions and limitations, under the same kinds of circumstances, within the full discretion, and in the course of the same kind of responsible deliberations as we as such minor's parents and/or guardian(s) would have to consider it. We further authorize such caring adult to arrange for and hire an ambulance or other emergency vehicle to transport, at our expense, such minor to a suitable place where medical or dental care is provided.

Dated \_\_\_\_\_

Witness \_\_\_\_\_ Signature of Parent or Guardian \_\_\_\_\_

Witness \_\_\_\_\_ Signature of Parent or Guardian \_\_\_\_\_

Address of Parent or Guardian \_\_\_\_\_ Emergency Telephone Number \_\_\_\_\_

Please answer the following statements (circle yes or no)

- My child:
1. (YES NO) Has a history of seizures or fainting. Explain \_\_\_\_\_
  2. (YES NO) Is a diabetic and takes insulin.
  3. (YES NO) Is subject to specific allergies. If Yes, please specify the type of allergy and medicine prescribed: \_\_\_\_\_
  4. (YES NO) Has a medical condition which may affect participation in any activity. If Yes, please explain: \_\_\_\_\_

**HEALTH AND ACCIDENT INSURANCE CARRIER:**

Carrier \_\_\_\_\_ Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

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