



Medical Treatment Authorization Form

Youth Program/Activity: _____

Name of Participant: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Existing Medical Coverage: _____ Plan # _____

Known Allergies: _____

Current Medications: _____

I hereby voluntarily permit my child to participate in the above program / activity at California State University, Northridge.

While my child is attending or traveling as part of this Activity/Program, I HEREBY AUTHORIZE THE EMPLOYEE/ADULT VOLUNTEER, or in his/her absence or disability, any adult accompanying or assisting him/her, TO CONSENT TO THE FOLLOWING MEDICAL TREATMENT FOR SAID MINOR: 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 general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practices Act, California Business and Professions Code Section 2000 et seq.; or any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a dentist licensed under the provisions of the Dental Practices Act, California Business and Professions Code Section 1600 et seq.

This authorization is given pursuant to the provisions of California Family Code Section 6910. This authorization shall remain effective until my child completes his/her activities in this program unless sooner revoked in writing. I understand that as a parent/guardian, I will be responsible for the cost of any service or treatment provided.

AUTHORIZATION, CONSENT, AND RELEASE

I hereby certify that my child is in good health and can participate in all functions of this Program as described above. I am the parent/guardian having legal custody of the youth member named above as stated under California Family Code Section 6550. I understand it is my responsibility to keep the information on this form updated (including Health History) by contacting the Program Employee.

Signature of Parent/Guardian

Date

NON-CONSENT

I do not desire to sign this authorization and understand that this will prohibit my child from receiving any non-life threatening medical attention in the event of illness or accident.

Signature of Parent/Guardian

Date