

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I/WE, the undersigned, parents/guardians of _____, a minor, do hereby authorize BAND DIRECTORS, CHOIR DIRECTORS, and/or TOUR CHAPERONES, as agents for the undersigned to consent to any treatment x-ray examinations, anesthetic, medical or surgical diagnosis and hospital care which is deemed advisable by, and is to be rendered under, the general or special provisions of the Medicine Practice Act on the medical staff of ANY ACCREDITED 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 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.

This authorization shall remain effective until August 31, 2012 unless earlier revoked in writing delivered of said agents.

SIGNED:

By Parent or Legal Guardian: _____ **Date:** _____

MEDICAL INSURANCE COMPANY: _____

Group Number: _____ **Policy Number:** _____

Other Insurance Information: _____

STUDENT FAMILY HISTORY

School: **Napa High School** Present Grade: _____ Date: _____

Student's FULL NAME: _____
Last First

Student's Date of Birth (MM/DD/YYYY) _____

Current Address of Residence: _____

Home Phone Number: _____

TURN OVER!!! → TURN OVER!!! → TURN OVER!!! →

Student's FULL NAME: _____
Last First

PARENT CONTACT INFORMATION:
MOTHER:

Last First Home Phone/Evening Phone

Cell Phone Work Phone

FATHER:

Last First Home Phone/Evening Phone

Cell Phone Work Phone

STUDENT HEALTH HISTORY

(Please provide dates where known; this information is confidential to Director and Chaperones Only)

Operation (within the past year): _____

Emotional Problems (i.e. hyperventilation, hysteria): _____

Serious Medical Issues: _____

	YES	NO
Rheumatic Fever:	_____	_____
Diabetes:	_____	_____
Epilepsy:	_____	_____
Allergies:	_____	_____
Allergic to Penicillin?	_____	_____

Allergies to any other drugs (if YES, please list): _____

Last TETNUS injection (date): _____

ANY SPECIAL HEALTH PROBLEMS IN THE PAST: _____

Any medications patient is currently taking (please include anti-convulsive, antihistamine, insulin, tranquilizers, etc.): _____

Is Student under medical treatment at present (list reason(s)): _____

Family Physician: _____ Physician Phone: _____