AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT FOR MINORS AND THOSE DEEMED INCOMPETENT

In the event the undersigned parent/guardian of _____,

cannot be contacted through reasonable efforts, does hereby empower and grant to:

Eureka Educational Ministries and La Mirada Christian Church personnel

the right to consent permission of any X-ray, examination, anesthetic, medical or surgical diagnosis, treatment and/or Hospital Care, to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state of California, when the need for such treatment in immediate, and when efforts to contact me (us) are unsuccessful. This authorization shall be valid for the period of time commencing on _____ and ending on _____. I do hereby indemnify and hold harmless the physician, hospital, and other persons who act in reliance upon this authorization.

Executed this_____ day of _____ 20____.

_____ __________

WITNESS PARENT/GURDIAN

INFORMATION:

Name/Phone number of family doctor, pediatrician, dentist:

_____

Any known allergies:_____

Medicines child is taking:_____

Insurance Company:_____

POLICY#:_____