Medical Treatment Authorization (Minors)

AUTHORIZATION FOR AGENT TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I hereby authorize _____ to consent to any x-ray,

(full name of an adult into whose care the minor has been entrusted)

examination, immunizations, anesthetic, all medical, dental, and mental health services, or surgical

diagnosis or treatment and hospital care of _____ deemed advisable

(full name of the minor)

by a license physician and surgeon and provided by that physician or under that physician's supervision,

regardless of where that treatment is provided.

This authorization is made under Family Code §6910.

This authorization supersedes any prior request for authorization to treat a minor submitted prior to the date below. It remains in effect until revoked in writing.

Signed: _____ Date: _____

Print Name: _____

Please specify relationship to minor:

□ Parent with legal custody

□ Guardian with legal custody

□ Other: _____