



COTATI-ROHNERT PARK UNIFIED SCHOOL DISTRICT

PARENT AUTHORIZATION FOR MEDICAL TREATMENT
(Confidential Information)

Student's Name _____ Grade _____

Address _____

Birthdate _____ M F Telephone Number _____

Message Phone _____

Doctor's Name _____ Phone _____

Name of Health Insurance _____ Policy # _____

Any known allergies _____

Father, Mother or Guardian's Name(s) (*please print*) _____

In the event of an emergency, if parents or guardian cannot be reached, please contact:

Contact #1 _____ Telephone _____
Name

Contact #2 _____ Telephone _____
Name

(I) (We), the undersigned, parent(s) of _____, a minor, do hereby authorize the principal, or designee, as agent for the undersigned to consent to 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 surgeon licensed under the provisions of the Medicine Practice Act, whether such a 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 agent(s) 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 shall remain effective until _____, 20__, unless sooner revoked in writing delivered to said agent(s).

Parent/Guardian Signature Name Date