



IMPERIAL VALLEY REGIONAL OCCUPATIONAL PROGRAM

Project WORKABILITY

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El Centro, CA 92243
(760) 482-2640
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Authorization To Treatment of Minor

Minor's Name: _____ Brithdate: _____

Home Address: _____ City: _____

Home Telephone #: _____ Parent Work Telephone #: _____

Message/Other Telephone #: _____

Doctor: _____ Hospital: _____

Known Allergies: _____

Special Physical or Medical Circumstances: _____

Instructions on Emergency Situations: _____

I, the undersigned Parent/Legal Guardian of the minor named above, do hereby authorize the above doctor and/or hospital agent for the undersigned to 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 the physician and/or surgeon licensed under the provisions of the Medicine Practice Act on the medical staff or licensed hospital in the State of California.

It is understood that an effort to contact me will be made and that this authorization is given in advance of specific diagnosis, treatment of hospital care being required to provide authority and power on the part of aforesaid agent, to give specific consent to any and all diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his or her best judgment may deem advisable.

This authorization shall remain in effect until the conclusion of the current youth training program or the minor's eighteenth birth date, unless sooner revoked in writing.

Signature of Parent/Legal Guardian

Date