

**AUTHORIZATION FOR CONSENT TO TREATMENT OF MINORS**

\_\_\_\_\_ has my permission to attend the  
regularly scheduled meetings of Unit No. \_\_\_\_\_ of \_\_\_\_\_  
(city)

The person to contact in an emergency is \_\_\_\_\_  
whose phone number is (\_\_\_\_\_) \_\_\_\_\_

While attending or traveling to and from meetings or activities, I hereby authorize the leaders of said unit, or in their absence or disability, an adult accompanying or assisting, to consent to an 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/or surgeon licensed under the provisions of the Medical Practice Act, or to consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to said minor by a dentist licensed under the provisions of the Dental Practice Act.

This authorization is given pursuant to the provisions of Section 6900 et. seg. Of the Family Code of California. This authorization shall remain effective until such time as my child withdraws from Unit No. unless sooner revoked in writing.

\_\_\_\_\_  
Date Phone Parent/Legal Guardian

NOTE: I do not desire to sign this authorization and understand this information will be in the leader's possession at regular meetings and special activities.

\_\_\_\_\_  
Date Phone Parent/Legal Guardian

\*\*\*\*\* Information Needed for Medical Coverage \*\*\*\*\*

We are covered by Medical Insurance: \_\_\_ Yes \_\_\_ No

If yes, name of Insurance Company \_\_\_\_\_

Policy No. \_\_\_\_\_ Employee's Name \_\_\_\_\_

\*\*\*\*\* Optional Information \*\*\*\*\*

TO THE LEADER: If the parent or legal guardian cannot be contacted in case of emergency the following person can be called:

\_\_\_\_\_  
Name Address Phone

Hospital to use: \_\_\_\_\_  
Name Address Phone

Doctor to use: \_\_\_\_\_  
Name Address Phone