2016-2017 Season

CYC Invitational

AUTHORIZATION FOR THIRD PARTY TO CONSENT TO TREATMENT OF A MINOR LACKING CAPACITY TO CONSENT 2016-2017

(To be filed with Team Organization, if required)

(I)/(We), the undersigned parent(s)/person(s) having legal custody/legal guardianship of _____

_____, minor, do hereby authorize _____

as agent(s) 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 or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such 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 to power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care, which a physician meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

(I)/(We) hereby authorize any hospital which has provided treatment to the above named minor pursuant to the provisions of Section 25.8 of the Civil Code of California to surrender physical custody of such minor to (my)/(our) above named agent(s) upon the completion of treatment. This authorization is given pursuant to Section 1283 of the Health and Safety Code of California.

I understand that any cost incurred for emergency medical, surgical, or dental treatment shall be my sole responsibility.

Medical Insurance Carrier _____

Group # _____

Does your child have any disabilities, handicaps, present injuries or limitations, allergies, hemophilia, heart condition, history of respiratory illness or any other significant medical condition? ☐Yes ☐No

If yes, please describe the condition below:

This authorization shall remain in effect until **OCTOBER 31, 2017** , unless sooner revoked in writing and delivered to said agent(s).

Relationship (check one) ☐Parent ☐Legal Guardian ☐Person having legal custody

Signature of Parent/Guardian	Print Name of Parent/Guardian	Date