BEAR RIVER SCHOOL
WHEATLAND SCHOOL DISTRICT
AFTER SCHOOL SPORTS

PARENT PERMISSION FOR TREATMENT OF MINOR: Date_____

Student_____Address_____
Home_____ Phone_____Work Phone_____

I. Authorization To Consent To Treatment of Minor: NOTE: This authorization form approved by the California Hospital Association. (We). the undersigned, parent(s) of_____, a minor, do hereby authorize the faculty member of Wheatland School District (Bear River School), supervising the activity concerned 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 general or special supervision of any physician and surgeon licensed under the provision of the Medical Practice Act on the medical staff of any licensed 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 and power on the part of our aforesaid agent 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 is given pursuant to the provision of Section 25.8 of the Civil Code of California. This authorization shall remain effective until_____unless sooner revoked in writing delivered to said agent.

II. Health Information

1. List any serious medical illnesses such as rheumatic fever, polio, etc., that the student has had _____
   _____
2. Is the function of any part of the student's body impaired? (stiff knee, weak shoulder, etc.)_____
   _____
3. Has the student lost completely the use of any part of his/her body? _____
4. Does the student have any allergy to any drug, etc.? _____
5. List any past serious injuries _____
6. List any operations _____
7. Does the student take any regular medication? _____
8. Does the student have dental appliance, fixed or removable? _____
9. Is there any reason you believe the student should not engage in the after school sports program?_____
   If so, explain _____

Date _____ Father's Signature _____

Mother's Signature _____

Family Doctor _____ Address _____