



AUTHORIZATION FOR AGENT TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I hereby authorize _____

(an adult into whose care the minor(s) has been entrusted) to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care of _____ (name of minor) deemed advisable by a licensed physician and surgeon and provided by that physician or under that physician's supervision, regardless of where that treatment is provided.

This authorization is made under Family Code 6910.

Signed: _____ Date: _____

Print Name: _____

Please specify relationship to minor:

Parent with legal custody

Guardian with legal custody