**If the participant is under 18 years of age, please complete the following:**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the undersigned parent and/or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ whose date of birth is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do hereby authorize medical and/or surgical treatment by a State of California licensed medical doctor (M.D.), and/or a State of California licensed hospital and/or licensed hospital emergency room and/or a private practice office operated by a State of California licensed medical doctor (M.D.), duly certified and licensed and/or their representatives as agent(s) for the undersigned to consent to any X–ray, laboratory, anesthetics, 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 a licensed medical doctor (M.D.) as per the provisions of the Medical Practice Act and who is on the staff of the accredited hospital, whether such diagnosis or treatment is rendered at the office of the treating physician or at any accredited hospital.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care required, but is given to provide authority, consent, and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his medical and surgical judgement may deem advisable pursuant to the provisions of § 25.8 of the Civil Code of California.

In addition, you are authorized to release and/or to receive any and all medical records and/or related medical information pertaining to and/or aiding in the treatment rendered the minor named above with regard to the minor/minor’s industrial accident/injury.

Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian’s Signature Date

Signature of Witness Date

**If participant is 18 years old or older, please provide an emergency contact. In case of emergency, please notify:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list personal physical information that hospital or physician should be aware of in case of illness or injury (i.e., diabetic, drug reactions, heart condition, drug/medications currently taking, allergies, etc.).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Participant’s Signature Date