WESTMONT

955 La Paz Road, Santa Barbara CA 93108
805 565-6164 • health@westmont.edu

Student's last name | First name | Birth date

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

(Needed only if the student is not yet 18 years old)

I, the undersigned, parent of ______________________________, a minor, do hereby declare that the care of said minor has been entrusted to the faculty and members of the administrative staff of **Westmont College**. The director of health services thereof is hereby authorized to act 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 the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital. The director is further authorized to consent to an 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.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, dental or hospital care being required, but is given to provide authority and power on the part of aforesaid agent to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician or dentist in the exercise of his/her best judgment may deem advisable.

The undersigned do hereby indemnify and hold harmless **Westmont College** and all members of the faculty and administrative staff thereof from any financial responsibility for so acting and the undersigned agrees to pay the reasonable and customary charges for any X-ray examination, anesthetic, medical or surgical diagnosis or treatment or hospital care provided to said minor pursuant hereto.

The authorization is given pursuant to the provision of Section 25.8 of the Civil Code of California.

The authorization shall remain effective until revoked in writing and delivered to **Westmont College**, director of health services.

Note: *Every effort will be made to contact parents in the event of an emergency.*

Date

Special Medical Information

Family doctor | Phone

Address | City | State | Zip

Parent or legal guardian's signature (full name, in ink)

Address | City | State | Zip

E-mail | Home phone | Work phone