Authorization to Consent to Medical Treatment of a Minor

After Hour Pediatrics Urgent Care Clinic

210 Baldwin Avenue, San Mateo, CA 94401

Phone # 650-579-6581 Fax # 650-579-7851

I hereby authorize _____

(An adult into whose care the minor has been entrusted)

to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care of

_____

_____

(Name, DOB & address of minor)

deemed advisable by a licensed physician and surgeon and provided y 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