

**MEDICAL RELEASE FORM  
AUTHORIZATION TO TREAT A MINOR**

I (we) the undersigned parent, parents or legal guardian of \_\_\_\_\_, a minor do hereby authorize and consent to any x-ray, examination, anesthetic, or surgical diagnosis rendered under the general or specific supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. 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 to render care which the aforementioned physician, in the exercise of his best judgment, may deem advisable. It is understood that the effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

THIS AUTHORIZATION IS GIVEN PURSUANT TO THE PROVISIONS OF SECTION 25.8 OF THE CIVIL CODE OF CALIFORNIA

\_\_\_\_\_  
ADDRESS CITY STATE ZIP

TELEPHONES: FATHER: \_\_\_\_\_  
MOTHER: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

\_\_\_\_\_  
ADDRESS PHONE

MEDICAL INSURANCE COMPANY: \_\_\_\_\_ POLICY #: \_\_\_\_\_

MINOR'S DATE OF BIRTH: \_\_\_\_\_ LAST TETANUS BOOSTER: \_\_\_\_\_

ALLERGIES TO DRUGS OR FOODS: \_\_\_\_\_

ANY SPECIAL MEDICATIONS OR INFORMATION—LIST ANY RESTRICTIONS: \_\_\_\_\_

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

\_\_\_\_\_  
SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

PLEASE RETURN IMMEDIATELY TO:

Southern California School Band & Orchestra Association  
11770 Warner Avenue Suite 110  
Fountain Valley CA 92708