California Inland Empire Council   Boy Scouts of America

AUTHORIZATION FOR CONSENT TO TREATMENT OF MINORS

____ has my permission to attend the

regularly scheduled meetings of Unit No.________ of______________________________________
(city)

The person to contact in an emergency is______________________________________

whose phone number is ( ) ______________________

While attending or traveling to and from meetings or activities, I hereby authorize the leaders of said unit, or in their absence or disability, an adult accompanying or assisting, to consent to an 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/or surgeon licensed under the provisions of the Medical Practice Act, or to consent to any 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.

This authorization is given pursuant to the provisions of Section 6900 et. seg. of the Family Code of California. This authorization shall remain effective until such time as my child withdraws from Unit No._ unless sooner revoked in writing.

______________ (   )______________ ______________________________
Date Phone Parent/Legal Guardian

NOTE: I do not desire to sign this authorization and understand this information will be in the leader's possession at regular meetings and special activities.

______________ (   )______________ ______________________________
Date Phone Parent/Legal Guardian

******************************** Information Needed for Medical Coverage ************************

We are covered by Medical Insurance ____ Yes ______ No

If yes, name of Insurance Company:______________________________________

Policy No.________________________ Employee's Name________________________

** Optional Information************************************

TO THE LEADER: If the parent or legal guardian cannot be contacted in case of emergency, the following person can be called:

______________________ ______________________________ ______________________
Name Address Phone

Hospital to use:______________________ ______________________ ______________
Name Address Phone

Doctor to use:______________________ ______________________ ______________
Name Address Phone

(authoriz.frm/7-97/ra)