



**AUTHORIZATION FOR THIRD PARTY TO CONSENT TO
TREATMENT OF A MINOR LACKING CAPACITY TO CONSENT**

vvvvvvvvvvvvvvvv

(I) (We), the undersigned, parents(s) / person(s) having legal custody / legal guardianship of:

_____ (Player's Name)

minor, do hereby authorize

Coach

as agent(s) 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 or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

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 to power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care, which a physician meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

(I) (We) hereby authorize any hospital which has provided treatment to the above named minor pursuant to the provisions of Section 25.8 of the Civil Code of California to surrender physical custody of such minor to (my) (our) above named agent(s) upon the completion of treatment. This authorization is given pursuant to Section 1283 of the Health and Safety Code of California

These authorization shall remain effective until: _____, 20____, unless sooner revoked in writing and delivered to said agents(s).

Signature of MOTHER or
GUARDIAN _____

Signature of FATHER or
GUARDIAN _____

(Both must sign)

Print Name: _____

Print Name: _____

ADDRESS _____

PHONE _____
(Home)

_____ *(Business or other emergency number)*

DATE: _____

FAMILY DOCTOR _____
(Name)

PHONE _____

DRUG ALLERGIES (if any) _____

INSURANCE COMPANY _____

POLICY #: _____

PRIMARY INSURED _____

EMERGENCY CONTACT & relationship: _____ Phone # _____

vvvvvvvvvvvvvvvv

This form must be filled out completely and is to be retained by the supervising SEYO representative for this child and must be available at his or her participating activity.