AUTHORIZATION FOR CONSENT OF MEDICAL TREATMENT FOR MINORS AND THOSE DEEMED INCOMPETENT

In the event the undersigned parent/guardian of _____, cannot be contacted
Print Student Name

through reasonable efforts, does hereby empower and grant to:

After School Achievement Program, Inc. *825 College Blvd. Ste. 102-411 Oceanside, CA 92057* *(760) 207-8611*
NAME **ADDRESS** **PHONE NUMBER**

the right to consent permission of any X-ray, examination, anesthetic, medical or surgical diagnosis, treatment and/or Hospital Care, to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state of California, when the need for such treatment in immediate, and when efforts to contact me (us) are unsuccessful. This authorization shall be valid for the period of time commencing on

_____ ending on _____. I do hereby indemnify and hold harmless the
1st day with ASAP Last day with ASAP

physician, hospital, and other persons who act in reliance upon this authorization. Executed this day of _____ .
Today's Date

_____ _____
WITNESS (signature) PARENT/GURDIAN (signature)

_____ _____
Witness (print name) Parent/Guardian (print name)

Please provide the following information:

Parent/Guardian current address & phone number: _____

Family doctor/Pediatrician (Name/Address/Phone): _____

Dentist (Name/Address/Phone): _____

Medicine(s) child is taking: _____ List any known allergies: _____

Medical Insurance Company: _____ POLICY#: _____

Dental Insurance Company: _____ POLICY#: _____