DEVILPUPS
YOUTH PROGRAM FOR AMERICA

Medical Treatment Authorization Form

Patient Info:

First Name _____ Last Name _____

Parent/Guardian:

First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Emergency Phone Number _____

I, the undersigned Custodial Parent/Guardian do hereby authorize and consent to any X-Ray, examination, anesthetic, medical or surgical diagnosis and or treatment rendered under the general or specific supervision for the Medicine Practice Act or dentist licensed under the provisions of the Dental Practice Act, and or the staff of any acute general hospital holding a current license to operate a hospital from the State of CA. Dept. 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/her best judgment may deem advisable. It is understood that 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 6917 of the Family Code of Ca. This authorization is effective the entire time my child is with Devil Pups, Inc. until after his/her graduation.

My child, has permission to take any over-the-counter medications in accordance with label instructions as needed while attending the summer encampment, Devil Pups, Inc.

___ Yes Exceptions (if none, state so) _____

___ No

_____ _____

Parent/Guardian Signature Date