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**AUTHORIZATION FOR AGENT TO
CONSENT TO MEDICAL TREATMENT OF A
MINOR**

Child's Name: _____ Date of Birth: _____
Child's Name: _____ Date of Birth: _____
Child's Name: _____ Date of Birth: _____

I hereby authorize the following adults:

_____ (Relationship to minor)
_____ (Relationship to minor)
_____ (Relationship to minor)

into whose care the minor has been entrusted, to consent to any physical exam, medical procedures including immunizations and treatments deemed advisable by a licensed physician and provided by that physician or under that physician's supervision, regardless of where treatment is provided.

This authorization is made under California Family Code 6910.

Signed _____ Dated _____

Print Name: _____ Relationship to Minor: _____

- () This authorization is to be in effect from _____ to _____.
- () This authorization is to remain in effect until revoked by the above signed.