# EMERGENCY MEDICAL TREATMENT AUTHORIZATION

Student's Name _____ Birth date _____

Address _____ Phone _____

I/we the undersigned, am/are the parent(s) or persons having legal custody of the above named minor. I/we now am/are entitled to full and complete custody of said minor child.

I/we hereby authorize **Seeds of Knowledge Preschool** in whose care the above named child has been entrusted by me/us, to consent to any x-ray examinations, anesthetic, medical or surgical diagnosis or treat-ment and hospital care to be rendered to said minor under the general and special supervision and upon the advice of a physician and surgeon licensed under the provisions of the California Medicine Practice Act and/or 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 provision of the California Dental Practice Act.

I/we will assume financial responsibility for medical costs.

_____

Print Name of Parent/Guardian's

_____

Parent/Guardian's Signature Date

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