SUNNYBROOK CHRISTIAN ACADEMY

1620 Pinn Rd. • San Antonio, TX 78227 • Phone # (210) 674-8000 • Fax # (210) 673-4603

For God and Country

AUTHORIZATION TO TREAT MINOR

To any Hospital, Clinic and/or Physician:

I (We), the undersigned parent(s), or legal guardian of (Minor's Name) _____ authorize any hospital or clinic or licensed physician to treat my/our child, charge with any X-ray examination, anesthetic, medical or surgical diagnosis rendered under th general or special supervision of any member of the medical staff of the hospital/clinic or office of a physician who are licensed in the state of Texas.

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 when the physician in the exercise of his best judgement may deem advisable.

It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that treatment will not be withheld if the undersigned cannot be reached.

List any restrictions to your authorization to treat minor:

_____

_____

Date minor received last tetanus/diphtheria booster: _____

List any allergies to drugs or foods minor may have:

_____

Any special medication(s) or other pertinent information on minor:

_____

_____

_____

This consent shall remain effective until the end of the minor's participation in Sunnybrook Athletics Program.

Insurance Provider: _____ Group #: _____

Address / Phone # : _____

Primary Care Physician/Clinic : _____

Address / Phone # : _____

_____ _____

(Print) Parent/Legal Guardian (Print) Coach

_____ _____

Signature of Parent/Legal Guardian Signature of Coach

_____ _____ _____ _____

Date Cell Phone Date Cell Phone