

INLAND VALLEY, LOMA LINDA or RANCHO SPRINGS REGIONAL MEDICAL CENTER

Child's Name _____ Date of birth _____

Home address _____

Date of last tetanus shot _____ Allergies _____

Person responsible for bill _____

Address _____

Employer _____ Phone () _____

Company

Address _____

Occupation _____

Insurance _____

Company name

Policy holder

Policy #

Medical # _____ Medicare# _____

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

Since minors cannot receive emergency treatment without the consent of a parent or guardian, it is suggested that anyone with children under the age of 18 have treatment authorization forms placed on file at the hospital. (I) (we) the undersigned, parent(s) of _____, a minor, do hereby authorize Murrieta Ranch Pre-School as agents for the undersigned to consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of Inland Valley Regional Medical Center, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

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 on the part of my (our) aforesaid agent(s) in the exercise of his best judgment may deem necessary.

This authorization shall remain in effect until July 10, 2019 unless revoked by written request. One parent/guardian signature needed.

Mother _____ Witness _____

Father _____ Witness _____

Legal Guardian _____ Witness _____