

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR & DISCLAIMER

(I)(We), the undersigned, parents or legal guardian of _____ a minor, do hereby authorize Temple Beth Emet as agent(s) for the undersigned to consent to any medical or surgical diagnosis or treatment of hospital care, as a result of any emergency, which is deemed advisable by and is to be rendered under the supervision of a licensed physician or surgeon.

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 our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his/her best judgment may deem advisable.

(I)(We) hereby authorize any hospital or medical care provider that has provided treatment to the above named minor to (my)(our) above named agent(s) upon completion of treatment.

We also agree to waive all claims against Temple Beth Emet or any of its agent(s) or employees and to hold harmless Temple Beth Emet and any of its agent(s) or employees for the accidental injury of my child or for the negligent act(s) or intended act(s) made by others which cause injury to my child or for the illness or death of my child occurring during or by reason of the youth activity. The authorization shall remain effective until **June 15, 2009** unless sooner revoked in writing delivered to said agent(s).

Date
Home Telephone:
Cell Phone:
Home Address:
Emergency Contact Name:
Phone:

Signature of Parent or Legal Guardian
MEDICAL INSURANCE INFORMATION
Carrier:
Address:
Group #:
Subscriber #:
Primary Insured:

Is your child taking any medication? _____
 Name of the medication(s), if any: _____
 Does your child have any allergies? _____

**TEMPLE BETH EMET OF BURBANK
 MORRIS GOLD RELIGIOUS SCHOOL
 600 N. Buena Vista Street, Burbank, Ca 91505
 (818) 843-7242**