California Hospital Medical Center Foundation
A Dignity Health Member

# Volunteer Emergency Information and Consent

Volunteer Information

Name:_____ Male__Female__Date of Birth:___/____/____
First Last

Address:_____
Number Street Unit City Zip

Known Allergies:_____Insurance Co:_____Policy No._____

Physician: _____(____)_____
Name phone

Parent/Guardian Information

Name:_____ Relationship _____
First Last

Address:_____
Number Street Unit City Zip

Daytime Phone:(____)_____ Evening Phone: (____)_____

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Authorization to Treat A Minor (Under 18 Years of Age)

I /We the undersigned parent, parents or legal guardian of _____, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable, rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medical practice Act, for a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State Of California Department of Public Health. It is understood that this authorization, given in advance of any specific diagnosis, treatment or hospital care being required, is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.
This authorization is given pursuant to the provisions of section 25.8 of the Civil Code of California.

List any restrictions:_____

_____ _____
Signature of Parent/Legal Guardian Date

California Hospital Medical Center Volunteer Services Department
Leavey Hall, Suite 304, 1401 S. Grand Ave., Los Angeles, CA 90015
phone (213)742-5707~fax (213)742-5875