



Family Name \_\_\_\_\_

## Medical Emergency Release Information

### EMERGENCY MEDICAL AND DENTAL TREATMENT

While your child is participating in an OCMA activity, an accident or emergency illness may occur which requires immediate attention without sufficient time to contact a parent or legal guardian. The California Legislature has authorized consent in advance by parents or legal guardian for such treatment (Section 6910 of the California Family Code). Below we afford you the opportunity to choose whether the authorization permitted by that statute shall or shall not be given respecting your child.

### AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

I(we) hereby authorize OCMA's representative or such substitute as he/she may designate from time to time as our agent(s) to consent to any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment or 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 Medical Practice Act or to consent to an X-Ray examination, anesthetic, dental or surgical diagnosis or treatment or hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any dentist licensed under the provisions of the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, hospital or otherwise.

Family Physician \_\_\_\_\_  
Name City Phone Number

Family Insurance Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_

1. \_\_\_\_\_  
**Student Name** Birth Date Date of Last Tetanus Shot

Is the Student taking Medication? \_\_\_No \_\_\_Yes \_\_\_\_\_  
 Specify & Dosage

\_\_\_\_\_  
 Restricted or Allergic to: FOODS Restricted or Allergic to: MEDICINES

2. \_\_\_\_\_  
**Student Name** Birth Date Date of Last Tetanus Shot

Is the Student taking Medication? \_\_\_No \_\_\_Yes \_\_\_\_\_  
 Specify & Dosage

\_\_\_\_\_  
 Restricted or Allergic to: FOODS Restricted or Allergic to: MEDICINES

3. \_\_\_\_\_  
**Student Name** Birth Date Date of Last Tetanus Shot

Is the Student taking Medication? \_\_\_No \_\_\_Yes \_\_\_\_\_  
 Specify & Dosage

\_\_\_\_\_  
 Restricted or Allergic to: FOODS Restricted or Allergic to: MEDICINES

\_\_\_\_\_  
**First Person We Should Contact** (PRINT PLEASE) Cell or Pager Phone Number Home Phone Number

\_\_\_\_\_  
**Second Person We Should Contact** (PRINT PLEASE) Cell or Pager Phone Number Home Phone Number

**X** \_\_\_\_\_  
**Parent or Legal Guardian's Signature** **Date Signed**