ONTARIO POLICE DEPARTMENT

YOUTH ACADEMY

Medical Release Information / Authorization to Treat Minor

I (we), the undersigned parent(s) or legal guardian of _____ , a minor, do hereby authorize and do consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under general or special emergency room staff of any acute general hospital holding a current state license to operate a hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care, which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatments will not be withheld if the undersigned cannot be reached.

In case of an accident or other emergency, if I, the parent or guardian, cannot be reached, I hereby authorize a representative of Ontario Police Department or Chaffey High School to make such arrangements as they consider necessary for my child to receive medical or hospital care, including necessary transportation. I further authorize the physician named below to undertake such care and treatment of my child, as he/she considers necessary. I authorize medical and/or hospital care and treatment to be performed by any licensed physician or surgeon.

The undersigned hereby agrees to bear all costs incurred as a result of the forgoing.

_____ _____

Signature (Father, Mother, or Guardian) Date

Name & Relation (Father, Mother, or Guardian)	Name & Relation (Father, Mother, or Guardian)
( )	( )
Home Phone	Home Phone
( )	( )
Work Phone	Work Phone
( )	( )
Cell Phone	Cell Phone

(OVER)

Medical Information

Medical Insurance Company

( ) Insurance Company Phone Number

Policy Number

Group Number

Policy Holders Name

Policy Holders Employer

Family Physician

( ) Phone

Health Information

My child has:

Special Medical Condition	☐ **Yes***	☐ **No**
Allergies	☐ **Yes***	☐ **No**
Special Medication	☐ **Yes***	☐ **No**
Special Dietary Requirements	☐ **Yes***	☐ **No**

***If YES, please specify below**