VALLEY VIEW VAULTERS INC.
11295 Orcas Ave.
Lake View Terrace, CA 91342
(818) 302-0153

AUTHORIZATION TO CONSENT FOR TREATMENT

(I/We) _____ do here by authorize Rick or Virginia Hawthorne or person or persons in charge of Valley View Vaulters, as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis and/or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physican and surgeon licensed under the Medical Practices Act of California on the staff of any licensed hospital, 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 and is given to provide authority and power on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the afore mentioned physician in the exercise of his best judgement may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

Vaulter Name _____ Birhday _____
Please Print

Address _____
Street City Zip

If A minor, Parent(s) or Legal Guardian(s) _____

Phone (Home) _____ Phone (Cell or work) _____

E-mail _____

Allergies _____

Parents Occupation _____

Doctor's Name _____ Phone _____

Emergency Name _____ Phone _____

Health Insurance Carrier _____ Policy Date _____

Policy Number _____ Valid Until _____

Signature _____ Date _____
A Parent or Guardian if vaulter is under 18 years of age.

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