KAISER PERMANENTE®

Greater Southern Alameda Area
CONSENT FOR TREATMENT OF A MINOR

_____
Print name of minor applicant

I _____, do hereby state that I am the parent/legal
Print Parent/Legal Guardian name

guardian of _____ and that I authorize and consent
Print name of minor applicant

physicians and employees of the Kaiser Permanente Medical Program to provide necessary urgent medical care and treatment to _____
Print name of minor applicant

in the event that urgent medical care becomes necessary or advisable in the interest of my child/ward's health and well-being while my child/ward is performing services for the Kaiser Permanente Medical Program during his/her student internship.

Under the circumstance as above, I understand that should a medical problem arise, an attempt will be made to notify me by telephone. The number I would like to be reached at is _____. In the event that I cannot be reached, I hereby give my consent to such medical treatment as deemed necessary, including but not limited to radiological procedure, laboratory tests, surgery, anesthesia and any necessary procedures to be rendered by a licensed physician and/or practitioner.

_____ _____
Signature of Parent or Legal Guardian Date