The Rob McLintock
CALIFORNIA SUMMER SCHOOL

MEDICAL AUTHORIZATION TO PROVIDE CARE FOR A MINOR

IMPORTANT: THIS FORM MUST PRECEDE OR ACCOMPANY YOUR ARRIVAL ON CAMPUS. YOU MAY NOT REMAIN ON CAMPUS WITHOUT IT. PLEASE COMPLETE AND RETURN.

Student Name:_____
Last First Middle

SS#:_____ Birth Date:_____

Home Phone:_____ Work Phone:_____

Address:_____
Street
_____
City State ZIP Code

I, the undersigned, do hereby authorize Sue Jacobi as agent for the undersigned to consent to any x-ray, examination, anesthetic, dental care, medical or surgical diagnosis or treatment and/or hospital care, and is to be rendered under the general or special supervision of, any licensed physician, dentist and/or surgeon, whether such diagnosis or treatment is rendered at the office of such physician, dentist, and/or surgeon, in a hospital or elsewhere.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the above-named agent to give specific consent to any and all such diagnosis, treatment, or hospital care which aforementioned physician, dentist and/or surgeon in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 6910 of the Family Code of California, or any successor code or provision.

These authorizations shall remain effective from June 14 2019 until June 21 2019, unless sooner revoked in writing delivered to the above named agent.

(OVER PLEASE)

EVIDENCE OF HEALTH INSURANCE

I, the undersigned, hereby warrant and guarantee that my son/daughter is covered by the health insurance described below and that I have signed this authorization authorizing an adult member or chaperone of the group as my (our) agent for purposes of authorizing any x-ray, examination, anesthetic, dental care, medical or surgical diagnosis or treatment and/or hospital care as may be required, in the opinion of such agent.

It is understood that in the event that my son/daughter require any x-ray, examination, anesthetic, dental care, medical or surgical diagnosis or treatment and/or hospital care, which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician, dentist and/or surgeon, whether such diagnosis or treatment is rendered at the office of such physician, dentist and/or surgeon, in a hospital care and that the insurance coverage described below shall constitute the primary insurance coverage for the cost of all such diagnosis, treatment, and/or hospital care.

I, the undersigned, understand and acknowledge that neither the Academy by the Sea nor Camp Pacific, nor the College of Piping California Summer School of Piping shall under any circumstances be responsible for the cost of any such diagnosis, treatment and/or hospital care.

INSURANCE INFORMATION

COMPANY: _____

POLICY #: _____

NAME OF INSURED: _____

INDIVIDUAL #: _____

NAME OF INSURED'S EMPLOYER: _____

DATE: _____ **_____**

PARENT'S SIGNATURE

_____

(Print name of person signing)

MEDICATIONS: _____
KNOWN ALLERGIES: _____
EMERGENCY PHONE NUMBERS: _____