

**THE FOLLOWING INFORMATION WILL BE USED FOR EMERGENCY PURPOSES ONLY***Please complete **one per child per activity, plus one additional copy for Membership.***Please check **ALL** activities your child is participating in:
Basketball  
 Dance  
 Bowling  
 Volleyball  
 Tennis  
 Golf  
 Summer Basketball

**San Jose Japanese Community Youth Service  
 EMERGENCY MEDICAL INFORMATION  
 AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR**

Name of Child \_\_\_\_\_ DOB \_\_\_\_\_

Parents/Guardians Name \_\_\_\_\_

Mother's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Mother's Phone Home: \_\_\_\_\_ Cell: \_\_\_\_\_ email: \_\_\_\_\_

Father's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Father's Phone Home: \_\_\_\_\_ Cell: \_\_\_\_\_ email: \_\_\_\_\_

**Emergency Contact if Parents are NOT Available:**

1. Name/Address/Phone \_\_\_\_\_

2. Name/Address/Phone \_\_\_\_\_

***Insurance Information (Do not leave any blank lines, if no policy/ID # or insurance, please write in "none")*****MEDICAL INSURANCE**

Primary Carrier \_\_\_\_\_ Policy/ID Number \_\_\_\_\_ Employer \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

**DENTAL INSURANCE**

Primary Carrier \_\_\_\_\_ Policy/ID Number \_\_\_\_\_ Employer \_\_\_\_\_

Dentist Name \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

**Pre-Existing Medical Conditions** \_\_\_\_\_

I, the parent /guardian of \_\_\_\_\_, a minor, authorize the adult leaders of San Jose Japanese Community Youth Service (JCYS), as agent(s) to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and 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 any X-ray examination, anesthetic, dental, medical or surgical diagnosis or treatment and hospital care to be rendered by a dentist licensed under the provisions of the Dental Practice Act. 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 part of our agent(s) to give specific consent to any and all diagnosis, treatment or hospital care which the physician or dentist in the exercise of his/her best judgment may deem advisable.

I authorize any hospital, which has provided treatment to the above named minor pursuant to the provisions of Section 6910 of the Family Code of California to surrender physical custody of such minor to my agent(s) upon completion of treatment. This authorization is given pursuant to Section 1283 of the Health and Safety Code of California.

This authorization shall remain effective until revoked in writing delivered to said agent(s).

\_\_\_\_\_  
**Signature of Parent/Guardian**\_\_\_\_\_  
**Date**\_\_\_\_\_  
**Signature of Parent/Guardian**\_\_\_\_\_  
**Date**