MEDICAL CONSENT/RELEASE FORM

Motor Development Clinic
College of Science
California State Polytechnic University, Pomona

As the undersigned Parent/Legal Guardian of _____, I request that in my absence the above named Minor Child be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, nurses, dentists and staff, to perform any diagnostic procedures, treatment procedures, and operative procedures to the above named individual. I have not been given any guarantee as to the results of any treatment if performed on the above name individual.

I hereby accept any financial responsibility for any and all medical treatment necessary to be administered to the above named Minor Child in the event of an accident, injury, sickness, etc.

I hereby state that my child is in good health, and has my permission to participate in this program.

Any authorized representative of the Motor Development Clinic is designated to act in my behalf until I have been contacted.

Student Name: _____

Student Address: _____

Family Physician:_____Phone: _____

Name of Parent/Guardian: _____

Address: _____

City/State/Zip: _____

Phone: (H) (_____)_____-_____ (W) (_____)_____-_____ Cell (_____)_____-_____

Person responsible for charges (if different from above): _____

Address: _____

City/State/Zip: _____

Phone: (H) (_____)_____-_____ (W) (_____)_____-_____ Cell (_____)_____-_____

Person to notify if parent/guardian is unavailable: _____

Phone: (H) (_____)_____-_____ (W) (_____)_____-_____ Cell (_____)_____-_____

Insurance Carrier(s): _____Policy Number: _____

Signature of Parent/Guardian: _____**Date**: _____