

SAN FRANCISCO CONSERVATORY OF DANCE

Medical Authorization – Non-Emergency

Date: _____

I/we, the undersigned parent(s) or legal custodian(s) of _____ (name of student), a minor, do hereby authorize the San Francisco Conservatory of Dance and its employees and representatives as the agent for the undersigned to consent to medical or dental care for the above-named minor, including x-ray, MRI, bone scan and other diagnostic imaging examination, anesthetic, dental, medical diagnosis or treatment under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act or a dentist licensed under 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 to our agent to give specific consent to any and all such diagnosis, treatment or hospital care which the physician, surgeon or dentist in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provisions of Sections 6901 - 6910 of the California Family Code. **If only one parent or custodian executes this authorization, I hereby certify that I have sole legal custody of the above-named minor.**

This authorization shall remain effective through the end of the school year, unless and until a written revocation is delivered to the Conservatory Director.

Print Mother/Guardian Name: _____

Mother/Guardian Signature: _____ Date: ____/____/____

Print Father/Guardian Name: _____

Father/Guardian Signature: _____ Date: ____/____/____

Student Signature (if over 18) _____ Date ____/____/____