

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR 2012 Cardinal Kids Camp

I/We, the undersigned, parent(s)/guardian(s) of				
Stanford University Staff, as agents for the undersigned, to consent to an <i>y</i> surgical diagnosis, or treatment and hospital care which is deemed advisa	•			
general or specific supervision of, any physician and/or surgeon licensed is country and no physician licensed to practice in any of the United States is physician deemed competent to render the necessary.	n any of the United States,	or, if in a foreign		
It is understood that this authorization is given in advance of any specific required but is given to provide authority and power on the part of our afany and all such diagnosis, treatment, or hospital care which the aforesaid judgment may deem advisable.	oresaid agent(s) to give spe	ecific consent to		
I understand that as a parent/legal guardian, I will be responsible for the c Stanford.	ost of any service or treatm	ent provided by		
This authorization shall be valid and effective from, 20 revoked sooner in writing delivered to Stanford.	012 until	2012 unless		
I understand that in order to provide timely and effective medical attention to a minor Stanford has requested the completion of the attached Voluntary Heath History Information.				
I understand that this form is voluntary and I () elect to, () elect not to cor	mplete this form.			
Signature:				
Name Printed (Parent/Guardian):				

Please submit all forms by email or fax to: Jessica Fitting Reunion Homecoming Registration Associate

Email: jfitting@stanford.edu

Fax: (650) 724-1552

Questions? (650) 724-3717



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VOLUNTARY HEALTH HISTORY INFORMATION				
This information is confidential and will be used only in case of emergency.				
Childs First Name	Last Name	Sex: M / F	Date of Birth	
		Does your child have or has		
Is your Child Subject to:	Yes or No	ever had:	Yes or No	
Colds		Heart Trouble		
Sore throat		Sinus Trouble		
Fainting spells		Hernia		
Bronchitis		Appendicitis		
Convulsions		Has appendix been removed?		
Cramps				
Allergies				
Date of child's last tetanus	vaccination:			
Please identify child's alle	rgies, including allergies to	food, medications, or drug reactions yo	u know about:	
Is your child currently und	der any type of medical trea	tment?		
If yes, please describe:				
Is your child currently taken any prescription medication?				
If yes, please identify name of medication, dosage, times taken:				
Please identify over-the-counter medications that we may administer. For example: Antacid, Aspirin.				
Please list any disabilities or disorders that may affect your child's participation, such as eyesight, hearing, speech,				
paralysis, diabetes, ulcer, etc.				
Is there any history of behavior disorders or emotional disturbances, such as difficulties in relationships with authority figures or peers, or abnormally severe moodiness?				
relationships with authority figures of peers, of abhormany severe modulicss:				
Has your child been under psychiatric treatment within the past three years?				
Thas your clinic been under psychiatric treatment whilm the past three years:				
Name, address and telephone number of child's physician				
I varie, address and telephone number of child's physician				
Remarks and any special instructions:				