

**CITY OF FULLERTON
AUTHORIZATION FOR MEDICAL TREATMENT OF A
VOLUNTEER UNDER THE AGE OF 18**

Short-term Volunteer - Volunteering less than two months AND less than 15 hours.

Long-term Volunteer - Volunteering 15 hours or more
Fingerprints are required for long term volunteers ages 16-17

I the undersigned parent(s)/Legal guardian(s) of _____, a minor, do hereby consent to and authorize the CITY OF FULLERTON and/or its officers, officials, agents, contractors, volunteers, boards, departments, servants or employees to obtain any necessary emergency medical care including X-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care for my/our child which is deemed advisable and rendered under the general or special supervision of a medical professional, including doctors, nurses, medical technicians, emergency room staff, EMTs, and paramedics.

I acknowledge that the CITY OF FULLERTON is not responsible for paying for the costs of any such emergency medical treatment that does not arise from the course or scope of the duties performed by my/our child on behalf of the CITY OF FULLERTON and that the CITY OF FULLERTON has no insurance to pay for the medical costs arising from such injuries, illnesses or medical conditions. I further agree that any such medical or related expenses incurred by my child will be my sole responsibility. (This does not apply to state mandated Workers' Compensation benefits.)

THIS AUTHORIZATION SHALL REMAIN IN EFFECT FOR TWO YEARS FROM THE DATE SIGNED OR UNTIL _____. The Undersigned hereby agrees to inform the CITY OF FULLERTON of any changes to the information contained within this authorization as soon as such new information is available. This authorization is given pursuant to the provisions of Family Code §6910.

Parent /Legal Guardian's signature

_____/_____/_____
Date

<p>Name and Address of Parent or Legal Guardian:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Home Phone: (____) ____ - _____</p> <p>Work Phone: (____) ____ - _____</p>	<p>Name and Address of Emergency Contact:</p> <p><input type="checkbox"/> Same as Parent/Legal Guardian</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Home Phone: (____) ____ - _____</p> <p>Work Phone: (____) ____ - _____</p> <p>Relationship to Minor: _____</p>
<p>Name and Address of Minor's Primary Physician:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Telephone: (____) ____ - _____</p>	<p>Minor's Healthcare Insurance Provider:</p> <p>Company: _____</p> <p>Group No.: _____</p> <p>Member No.: _____</p> <p>(Staple copy of insurance card to this form)</p>

List any and all medical conditions, disabilities, or diseases the minor has of which the City of Fullerton staff should be aware (Including allergies, seizures, etc.). _____

Special Remarks or Reminders: _____