AUTHORIZATION FOR MEDICAL OR HOSPITAL EMERGENCY CARE

To: Pomona Valley Hospital and Medical Center,
1798 North Garey Avenue
Pomona, California 91767
(909) 865-9500

In case of my absence from the city or the inability to reach me in an emergency, I hereby authorize Pomona Valley Hospital and Medical Center and their physicians to give whatever care in their opinion is deemed necessary to my child/children, and I also give the Hospital personnel authority to consult with physicians of their choice in the care of my child, if necessary.

Please feel free to contact the physicians named below for medical history which may assist you in making decisions concerning my child/children.

Doctor:_____ Phone:_____

Doctor:_____ Phone:_____

I also hereby give my consent to the performance of emergency care and/or hospitalization, including the performance of surgery with whatever anesthesia is necessary at the discretion of the surgeon and the anesthesiologist.

	CHILDREN	AGE	DATE OF BIRTH
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

This authorization will remain valid during the time my child attends Cal Poly Pomona Children's Center.

_____ _____
Parent Signature Date

_____
Address

_____
City, State, Zip

(_____)_____
Phone