

**The San Francisco Zen Center  
Coming of Age Program**

**Medical Release Authorization of Consent to Treatment**

Student's name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip Code \_\_\_\_\_  
Birth date: \_\_\_\_\_  
Parent e-mail: \_\_\_\_\_

**General Emergency Procedure:** *In the event of a medical emergency the San Francisco Zen Center will attempt to exercise good judgment in light of the circumstances. In general, we try to notify the parent or guardian, or other designated person, prior to the student receiving medical treatment. If this is not possible, we proceed as we think best. In the event of a severe injury, we will call 911 (or the equivalent) and attend to the immediate needs of the student before attempting to contact anyone else.*

**Emergency Contact Information:**

Mother: Home \_\_\_\_\_ Work \_\_\_\_\_  
Cell \_\_\_\_\_

Father: Home \_\_\_\_\_ Work \_\_\_\_\_  
Cell \_\_\_\_\_

Guardian: Home \_\_\_\_\_ Work \_\_\_\_\_  
Cell \_\_\_\_\_

Health Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_  
Student's regular physician \_\_\_\_\_  
Physician's phone \_\_\_\_\_

*In the event of any accident, emergency, or other situation calling for medical care during the scheduled Coming of Age Program sessions, as the parent or legal guardian of the above-named student, a minor, I/we authorize The San Francisco Zen Center and its adult employees and representatives as my/our agent to consent to any medical, hospital, surgical and/or dental medical or surgical diagnosis or*

*treatment and hospital care for the named student to be rendered under the supervision and upon the advice of a licensed physician, surgeon or dentist, or other licensed emergency medical personnel. This authorization is given in advance of any specific diagnosis, treatment or hospital care, and is given to provide authority and power to our agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care that the physician, surgeon or dentist in the exercise of his/her best judgment may deem advisable.*

*We agree that we are financially responsible for all medical, dental and emergency expenses incurred above and beyond expenses that may be covered by the San Francisco Zen Center's insurance policies. This authorization shall remain in effect for one full year from the date I/we sign this authorization.*

Dated \_\_\_\_\_  
Parent/Guardian's Signature \_\_\_\_\_  
Relationship: \_\_\_\_\_

Dated \_\_\_\_\_  
Parent/Guardian's Signature \_\_\_\_\_  
Relationship: \_\_\_\_\_