

**MEDICAL CONSENT/RELEASE FORM**  
Motor Development Clinic  
College of Letters, Arts, and Social Sciences  
California State Polytechnic University, Pomona

As the undersigned Parent/Legal Guardian of \_\_\_\_\_, I request that in my absence the above named Minor Child be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, nurses, dentists and staff, to perform any diagnostic procedures, treatment procedures, and operative procedures to the above named individual. I have not been given any guarantee as to the results of any treatment if performed on the above name individual.

I hereby accept any financial responsibility for any and all medical treatment necessary to be administered to the above named Minor Child in the event of an accident, injury, sickness, etc.

I hereby state that my child is in good health, and has my permission to participate in this program.

Any authorized representative of the Motor Development Clinic is designated to act in my behalf until I have been contacted.

Student Name: \_\_\_\_\_

Student Address: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: (H) (\_\_\_\_)\_\_\_\_ - \_\_\_\_ (W) (\_\_\_\_)\_\_\_\_ - \_\_\_\_ Cell (\_\_\_\_)\_\_\_\_ - \_\_\_\_

**Person responsible for charges** (if different from above): \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: (H) (\_\_\_\_)\_\_\_\_ - \_\_\_\_ (W) (\_\_\_\_)\_\_\_\_ - \_\_\_\_ Cell (\_\_\_\_)\_\_\_\_ - \_\_\_\_

**Person to notify if parent/guardian is unavailable:** \_\_\_\_\_

Phone: (H) (\_\_\_\_)\_\_\_\_ - \_\_\_\_ (W) (\_\_\_\_)\_\_\_\_ - \_\_\_\_ Cell (\_\_\_\_)\_\_\_\_ - \_\_\_\_

Insurance Carrier(s): \_\_\_\_\_ Policy Number: \_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_