



THE CRUCIBLE

an Educational Collaboration of
Arts • Industry • Community

info@thecrucible.org
http://www.thecrucible.org

510 • 444 • 0919 fax 510 • 444 • 0918
1260 7th Street, Oakland, CA 94607

The Crucible Youth Parental Permission to Treat and Information Form

Pickup Authorization and Emergency Contact Information

Youth full name: _____ Age: _____ Date of Birth: _____

Parent/Guardian _____ (Relationship) _____

In emergency please contact:

- | | |
|----------------|--------------|
| 1. Name: _____ | Home # _____ |
| Work # _____ | Cell # _____ |
| 2. Name: _____ | Home # _____ |
| Work # _____ | Cell # _____ |

Medical Information:

Primary physician _____ phone number _____

Medical Insurance No _____

Please list any special needs your child has with behavior, learning physical limitations, medical considerations/allergies, etc.

Youth Name

Pick-up Authorization: The following person(s) are authorized to pick up my child from the program

Name of Driver _____ Driver's phone # _____

Name of Driver _____ Driver's phone # _____

Anyone authorized to pick up the child will be asked to provide individual photo identification for themselves, such as a California Driver's License when picking up.

Permission to Treat:

Parental Authorization for Treatment of a Minor Child

I, _____, am the parent or legal guardian having custody of _____, a minor child. As such parent or legal guardian, I hereby authorize and appoint The Crucible of Oakland, CA in whose care the minor child has been entrusted as my agent to act for me with respect to my minor child and in my name in any way I could act in person to make any and all decisions for me with respect to my minor child concerning my minor child's personal care, medical treatment, hospitalization, and health care; and to require, withhold, or withdraw any type of medical treatment or procedure, including X-ray examination, anesthetic, medical or surgical diagnosis or treatment which may be rendered to my minor child under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state in which treatment is sought. My agent shall have the same access to my minor child's medical records that I have, including the right to disclose the contents to others. I understand that I am personally responsible for all costs incurred in the treatment of any injuries to the minor child.

By signing below, I acknowledge that I have read, understand and executed this agreement as of the date shown.

Parent/Guardian: _____

Date: _____