I/We, the undersigned parent(s) and/or legal guardian(s) of hereby authorize my child to attend the afterschool tutoring at Sanchez Elementary, 901 North Sanborn Road, Salinas, CA.93905 after school from 2:45 PM – 4:30 PM as a representative of Palma School. It is our understanding that the above program will be supervised by Palma’s Director of Campus Ministry, Mr. William Beesley, his/her Theology 10 teacher, and my child will be transported to and from this event by school van/bus.

California Civil Code, Section 25.8 expressly provides that a parent may authorize an adult into whose custody a child is entrusted to consent, if necessary, to medical and dental treatment:

*Either parent, or a guardian having legal custody of a minor may give written authorization for an adult into whose care the minor has been entrusted to consent to X-ray examinations, anesthesia, medical or surgical diagnosis, and/or treatment and hospital care to be rendered to said minor under the general or special supervision and advice of a physician or surgeon licensed under the provisions of the Medical Practice Act, or to X-ray examinations, anesthesia, dental and/or surgical diagnosis or treatment and hospital care to be rendered to said minor by a dentist licensed under the provisions of the Dental Practice Act.*

Accordingly, I/We hereby authorize Palma School to procure emergency medical, hospital, or dental care for my/our minor child, in the event of injury or illness while he/she is in the care of an adult acting on behalf of Palma School. It is understood that effort(s) will be made to contact the parent(s) and/or legal guardian(s) of my/our child before treatment is given. I/We understand, and agree that I/We am/are financially responsible for any care so procured.

**Printed name of Parent 1/Guardian 1 Date Printed name of Parent 2/ Guardian 2 Date**

**Signature of Parent 1/ Guardian 1 Date Signature of Parent 2/ Guardian 2 Date**

**Parent’s/Guardian’s Phone Number(s)**

The following medical condition(s) apply to the above-named participant:

☐Epilepsy ☐Allergies/Medicine ☐Asthma ☐Diabetes ☐Other:

Special Health Conditions or Instructions:

Print Name of Family Physician Physician’s Phone Number

Print Name of Family Dentist Dentist’s Phone Number

Print Name of Medical Insurance Coverage Insurance Policy or Group Number

Other Information: