**VENTURA COUNTY COMMUNITY COLLEGE DISTRICT**
District Administration Center
333 Skyway Drive, Camarillo, CA 93010
(805) 384-8300

☐**Moorpark College** ☐**Oxnard College** ☐**Ventura College**

## AUTHORIZATION TO CONSENT TO TREATMENT

I, _____, the undersigned, do hereby authorize the District as agent(s) for the undersigned that, in the event of illness or injury, I do consent to whatever x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgement of the attending physician, surgeon, or dentist, licensed under the provisions of the Medical Practices Act, and performed by or under the supervision of a member of the medical staff of any accredited hospital or facility furnishing medical or dental services. It is understood that resulting expenses will be my responsibility

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgement may deem advisable.

This authorization shall remain effective until _____, unless sooner revoked in writing delivered to said agent(s).

I acknowledge that I have read the rules set forth by the Athletic Department of the College and will abide by all of the rules set forth.

I acknowledge that I have read and signed the "Voluntary Activities Participation Form" and understand the information contained in the warning about serious, catastrophic and, perhaps, fatal accidents.

_____

Student Name (Print) Signature Date

*A signed **AUTHORIZATIOBN TO CONSENT TO MEDICAL TREATMENT** must be on file with the District before a student will be allowed to participate in the above extra-curricular/co-curricular activities.*