

AUTHORIZATION FOR MEDICAL CARE OF A MINOR

I, _____, the undersigned parent or person having legal custody or the legal guardian
parent/legal guardian name

of _____, do hereby authorize a representative of the Alva Independent School District #001
student name

to consent to any x-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment and hospital care to be rendered to the above named minor under general or specific supervision and upon the advice of a physician, surgeon, or dentist licensed under the laws of the State of Oklahoma.

In giving this consent, I recognize and understand that in situations where the above named minor requires immediate medical or hospital care, it may be not possible to contact me, and that in such situations, I will not be able to knowledgeably evaluate and choose among the available alternative treatments or procedures, if any, or to evaluate the risks attendant upon each, and the risks attendant to foregoing all treatment; in such situations, I authorize a physician, surgeon, or dentist to exercise his professional judgment and assess the risks incident to the student, and choose the necessary treatment from any available alternatives and to render such care and perform such treatment as he in his professional judgment determine to be necessary for the health or safety of the above named minor.

Date

Signature of parent/legal guardian

Address

City

State

Zip

Phone

Alternate person to contact if parent is unavailable _____

Name

Phone

TREATMENT INFORMATION

Minor's Birthdate _____

Date of last tetanus shot _____

Minor's Doctor _____

Name

Address

Phone

Minor's allergies _____

Medicine minor is taking _____

Minor's medical history _____

Insurance Company _____

Policy number _____

Preferred hospital _____