AUTHORIZATION FOR MEDICAL CARE OF A MINOR

I,_____, parent/legal guardian of:
Parent/Legal Guardian Name (Please Print)

_____
Minor's Name (Please Print)

DO HEREBY AUTHORIZE Anadarko Public Schools' Staff
To CONSENT to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, hospital care, immunization, blood test, examinations, guidance services and/or mental health services to be rendered to the above named minor under general or special supervision and upon the advice of a school nurse, physician, surgeon, dentist, or mental health counselor 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 or hospital care it may not be 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 to foregoing all treatment; in such situations, I authorize a school nurse, physician, surgeon, dentist, or licensed mental health counselor to exercise his/her professional judgment and assess the risks of incident to and choose necessary treatment from any available alternatives and to render such care and perform such treatment as he/she in his/her professional judgment determines to be necessary for the health or safety of the above named minor.

_____ _____
(Signature of parent/legal guardian) (Date)

_____ _____
(Telephone Number) (Cell Phone Number)

_____
(Address)

_____
(City) (State) (Zip Code)

Treatment Information:

Minor's Date of Birth:_____

Minor's Doctor:_____
(Name and Telephone Number)

Minor's Allergies:_____

Medication Minor is taking:_____

Date of Minor's Last Tetanus Shot:_____

Minor's Medical History:_____

_____

_____