Authorization for Medical Care of a Minor

I, _____, the undersigned parent or person
(Please Print Parent/Guardian Name)

having legal custody or the legal guardian of _____
(Please Print Minors Name)

DO HEREBY AUTHORIZE CENTRAL HIGH PUBLIC SCHOOLS

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 special 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 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 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 risks incident to and choose the necessary treatment from any available alternatives and to render such care and perform such treatment as he in his professional judgment determines to be necessary for the health or safety of the above minor.

_____ _____
Date Signature of Parent/Guardian

_____
Address Telephone Cell Phone

_____
City State Zip Code

Treatment Information:

Minor's Birth Date: _____

Minor's Doctor (Name & Phone No.) _____

Minor's Allergies: _____

Medicine Minor is taking: _____

Date of Minor's Last Tetanus Shot: _____

Minor's Medical History: _____

_____

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