AUTHORIZATION FOR MEDICAL CARE OF A MINOR

I, ____
(please print name)
the undersigned parent having legal custody or the legal guardian of:

____
(please print minor's name)

DO HEREBY AUTHORIZE FRIEND SCHOOL
(Name of person whom child is entrusted)

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 judgement 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 named minor.

________________ ____
(Date) (Signature of parent or person having legal custody or legal guardian)

________________ ____
(Telephone) (Address)

____
(City) (State) (Zip)

TREATMENT INFORMATION

Minor's Birth Date: ____________________

Minor's Doctor (Name and Telephone No.) ____________________

Minor's Allergies ____________________

Medicine Minor is Taking ____________________

Date of Minor's Last Tetanus Shot ____________________

Minor's Medical History ____________________

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We are happy to provide this form for Authorization for Medical Care of a Minor, which is designed in accordance with Oklahoma law. It gives permission for a physician or dentist to provide necessary care to a child whose parents are not immediately available. All blanks should be filled in. THIS CONSENT IS NOT VALID IF THE CARE OF A CHILD IS ENTRUSTED TO A PERSON UNDER 18 YEARS OF AGE. The form should always be left with an adult. DO NOT MAIL IT TO THE HOSPITAL.

GRADY MEMORIAL HOSPITAL
2220 IOWA, CHICKASHA, OK 73018
(405)224-2300