

School # 2021

MEDICAL AND HEALTH INSURANCE INFORMATION AND CONSENT FOR MEDICAL OR DENTAL CARE OF A MINOR

We would appreciate it if you would please submit all Form M's in alphabetical order by last name.

Student: Last Name, First, Middle, Mother or Guardian: Last Name, First, Father or Guardian: Last Name, First, Birth Date (mo/day/yr), Age, Grade, Home Phone, Emergency Contact Phone, Home Address, Home Phone, City, State, Zip

Medical/Health Insurance With: Phone, Address of Insurance Company, Policy Holder, Policy Number

AUTHORIZATION FOR EMERGENCY CARE TO MINOR(S)

In case of emergency illness or accident, the child is given first aid and the parents will be notified. If the parents or the child's doctor cannot be located, the child will be taken to the St. Francis Emergency Room, Tulsa, OK.

We the undersigned, parent(s) or legal guardian of the minor(s) listed below:

(Minor's Name) Birth Date:

do hereby authorize any X-ray examination, anesthetic, dental, medical or surgical diagnosis, or treatment by any physician or dentist licensed by the state of Oklahoma and hospital service that may be rendered to said minor under the general, specific, or special consent of an acting agent of ORU Christian School Finals Competition, the temporary Custodian of the minor, whether such a diagnosis or treatment is rendered at the office of the physician or dentist, or at a hospital licensed by the state of Oklahoma. I/we authorize the physician(s) or dentist(s) to call in any necessary consultants, in his/their discretion.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage those persons who have temporary custody of the minor, and said physician(s) or dentist(s) who have temporary custody of the minor, and said physician(s) or dentist(s) to exercise his/their best judgment as to the requirements of such diagnosis or medical or dental or surgical treatment. If ambulance service is needed, I/we authorize a call for emergency service.

This consent shall remain effective until ____ a.m./p.m. on the ____ day of _____, 20____, unless sooner revoked in writing, delivered to said physician or dentist or to said persons entrusted with the custody, care, and control of said minor child or children.

DATED

Witness: (Other than Custodian(s)) Father / Mother, Legal Guardian

AUTHORIZATION OF NONPRESCRIPTION MEDICATION

The staff ORU Christian School Finals Competition has my permission to administer the following if needed to my child:

Table with 4 columns: Medication Name, Yes, Initial, No, Initial. Rows include Aspirin, Tylenol, Advil, Decongestant, Anti-Histamine, Throat Lozenges, Pepto-Bismol.

If allergic to any medications, please specify:

If there are any physical problems or any special instructions, please comment: