TALOGA PUBLIC SCHOOLS
AUTHORIZATION FOR MEDICAL CARE OF A STUDENT

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

legal guardian of ____ do hereby give consent to any x-ray examination,
(please print student's name)

anesthetic, medical, surgical or dental diagnosis treatment and hospital care to be rendered to the above name student 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 CONSENT, I recognize and understand that in situations where the above student 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 the 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 student. In case of an emergency, I authorize officials to sevure the use of an ambulance, if necessary, for transporting my child to the hospital. I authorize school personnel to provide first aid or medical treatment to my child in the event of an injury occurring during school hours or school functions.

TREATMENT INFORMATION:

Student's Date of Birth: ______________ Date of Student's Last Tetanus Shot: __________ Student's SSN: ______________

Student's Doctor: ______________________________ Doctor's Phone Number: ______________________

MEDICAL INFORMATION: circle one. If YES, give needed information.

Heart condition or disease	YES NO	Asthma	YES NO	If YES, list: ______________
Diabetes	YES NO	Allergic to medication	YES NO	If YES, list: ______________
Convulsions disorder	YES NO	Allergic to insect stings	YES NO	If YES, list: ______________

Allergies: ____

Medicine Student is currently taking: ____

Student's Medical History: ____

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Circle: Insurance / Medicaid / None Insurance/Medicaid Policy Number: ______________________

Insurance Company Name: ____

Signature: ____ Date: ______________________
(Parent or person having legal custody or legal guardian)

Address: ______________________________ Phone number (Cell): ______________________

______________________________ Phone number (Work): ______________________

______________________________ Phone number (Home): ______________________