AUTHORIZATION FOR EMERGENCY CARE TO MINOR

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

______________________________________ Birth date: ____________________
(Minor's Name)

______________________________________ Birth date: ____________________
(Minor's Name)

______________________________________ Birth date: ____________________
(Minor's Name)

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 consent of:

____
(Name of adult person who is temporary custodian of minor)

the temporary custodian of the minor, whether such 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 or dentist to call in any necessary consultants, is his/their discretion. We further authorize said physician or dentist to exercise his/their discretion in authorizing the disposal of any severed tissues or member.

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 or dentist to exercise his/their best judgment as to the requirements of such diagnosis or medical or dental or surgical treatment.

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 said persons entrusted with the custody, care and control of said minor child or children.

Dated: _________________________ Father: _________________________________

Mother : ________________________________

Legal Guardian: __________________________

Witness other than custodian (s): ______________________________