APPOINTMENT OF AGENT
AUTHORIZATION FOR MEDICAL CARE OF A MINOR

I,_____, the undersigned parent or person having legal custody or the legal guardian
parent/legal guardian name

of _____, do hereby authorize a representative of the Alva Independent School District #one to
student name

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 treatment or procedures, if any, or to evaluate the risks attendant upon each, and the risks attendant to forgoing all treatment; in such situations, I authorize a physician, surgeon or dentist to exorcise his professional judgment and assess the risks incident to the student,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/legal guardian

_____
address city state zip phone

Alternate person to contact if parent is unavailable _____
name phone

TREATMENT INFORMATION:

Minor's birthdate _____ Date of last tetanus shot _____

Minor's Doctor_____
name address phone

Minor's allergies_____

Medicine minor is taking_____

Minor's medical history_____

Insurance Company _____ Policy Number_____

Preferred hospital_____