

ORU COLLEGE PREPARATORY INSTITUTE

Form M - Medical and Health Insurance information and Consent for Medical or Dental Care of a Minor

Student: Last Name		First	Middle	Mother or Guardian: Last Name		First
Male	<input type="checkbox"/>	Female	<input type="checkbox"/>	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:

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, or special consent of an acting agent of ORU College Preparatory Institute, 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/her 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/her 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 of ORU College Preparatory Institute has my permission to administer the following if needed to my child:

	Yes	Initial	No	Initial
Aspirin	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Tylenol	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Advil	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Decongestant	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Anti-Histamine	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Throat Lozenges	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Pepto-Bismol	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____

Please list allergies, if present: :

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