



AUTHORIZATION FOR EMERGENCY CARE TO A MINOR

Reference: Title 10 O.S. (1974 Supp.) Section 170.1

In case of emergency illness or accident, the student is given first-aid and the parents are notified. If the parents or the student's doctor cannot be located, the student will be taken to a hospital emergency room. Grace Christian School, Inc. does not assume responsibility for the payment of hospital, doctor, or ambulance fees.

Student's Name _____ Birth date _____ Grade Level 09-10 _____

Policy Holder _____ Policy Number _____

Health Insurance _____

Doctor's Name _____ Telephone Number _____

Hospital Preference _____

I/We the undersigned, parent(s) or legal guardian of the minor listed above, do authorize any X-ray, examination, anesthetic, dental, medical or surgical diagnosis or treatment by any licensed physician or dentist and hospital service which may be rendered to said minor under the general, specific, or special consent of Grace Christian School, Inc. or a representative thereof, the temporary custodian of minor; whether such diagnosis or treatment is rendered at the office of the physician or dentist, or at a licensed hospital. I/We authorize the physician or dentist to call in any necessary consultants, in his/their discretion.

It is understood 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 12:00 midnight on the 31st day of May 2010, 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.

1. Please list any injuries, surgeries, or serious illnesses your child has had in the past year. _____

2. Please indicate if your child wears corrective lenses, hearing aids, orthopedic devices, prosthesis, orthodontic devices, etc.

3. Please list any chronic illnesses such as asthma, diabetes, heart disease, seizures, ADHD, psychiatric disorders, etc.

4. Please list any physical limitations or restrictions the school should be aware of at this time. _____

5. Please list any allergies i.e. food, medication, or environmental. _____

6. Please list any medications your child is currently taking. _____

The staff of Grace Christian School, Inc. has my permission to administer the following, if needed, to the student named above:

- | | | |
|-------------------------|------------------------------|-----------------------------|
| Acetaminophen (Tylenol) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ibuprofen (Advil) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Antacid (Tums) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Father's/Guardian's Signature _____ Date _____

Mother's/Guardian's Signature _____ Date _____

Please list any other pertinent medical history or information on the back of this form.