

COMPLETE AND SUBMIT TO:
University of Oklahoma
OU Health Services
620 Elm Avenue
Norman, OK 73019-3146
P(405)325-4611 F(405)325-7542
healthservices@ou.edu

AUTHORIZATION FOR MEDICAL CARE OF A MINOR

Please Print Legibly & Complete Entire Form

Please check the appropriate statement for your circumstances.

I, _____
Last Name First Name Middle Name

The undersigned parent or person having legal custody of

Minor's Last Name First Name Middle Name

Date of Birth

do hereby authorize (check one of the boxes below):

Name of person(s) to whom minor is entrusted to:

Last Name First Name Middle Name

Address City State Zip Phone

to consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and/or hospital care rendered to the above minor, as is deemed necessary and appropriate, upon the advice of a physician, surgeon, or dentist, licensed under the laws of the State of Oklahoma.

- OR -

Any physician or other designated health care provider employed by OU Health Services, 620 Elm, Norman, OK to perform or render any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and/or hospital care rendered to the above minor, as deemed appropriate and necessary in promoting the health and well-being of the above named minor.

This authorization shall be placed on file within the facility and shall remain in effect until revoked in writing by parent or person having legal custody of the above named minor or until the named minor becomes of majority age (18 years old).

Signature of parent or person having legal custody Date

Address City State Zip

Telephone number where parent or legal guardian may be reached:

Work: _____ Home: _____ Other: _____

- OVER -

Medical History

Please complete the information below. In the event that we must provide medical care for your child, the following information may be helpful in determining proper treatment.

Minor's Allergies: _____

Date of Minor's Last Tetanus Injection: _____

Current Medicine(s) Minor Is Taking: _____

Minor's Significant Medical History: _____

Minor's chronic Illnesses (if any): _____

Hospital Preference: _____
