St. John Health System

1SJ18

AUTHORIZATION FOR EMERGENCY CARE TO MINOR(S)

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 in Oklahoma and hospital service that may be rendered to said minor under the general, specific or special consent of:

_____
(NAME OF ADULT PERSON(S) WHO IS TEMPORARY CUSTODIAN OF MINOR)

the temporary Custodian(s) of the minor; whether such diagnosis or treatment is rendered at the office of the physician or dentist, or at a hospital licensed in Oklahoma. I/We authorize the physician or dentist to call in any necessary consultants, in 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.

The consent shall remain effective until _____

_____ , 20 _____ unless sooner revoked in writing, delivered to said physician or dentist or to said person(s) entrusted with the custody, care and control of said minor child or children.

Dated _____

_____
FATHER

_____
WITNESS (OTHER THAN CUSTODIAN)

_____
MOTHER

_____
LEGAL GUARDIAN

Group Health Insurance

Policy Number _____

I can be reached at _____
TELEPHONE NUMBER