AUTHORIZATION FOR EMERGENCY CARE TO MINOR(S)

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

In case of emergency illness or accident, the student will be given first aid and the parents will be notified. If the parent's or the student's doctor cannot be located, the student will be taken to St. Francis Hospital at Broken Arrow emergency room or nearest available hospital. **Immanuel Lutheran Christian Academy** does not assume responsibility for the payment of hospital, doctor or ambulance fees.

Student's name:_____ Birth date_____

Policy Holder_____ Policy Number_____

Health Insurance Provider _____

Doctor's name_____ Telephone #_____

I/We the undersigned, parent(s) or legal guardians of the minor listed above, do authorize any X-rays, examination, anesthetic, dental, medical or surgical diagnosis or treatment by any licensed physician or dentist and hospital service that may be rendered to said minor under the general, specific or special consent of **Immanuel Lutheran Christian Academy** or 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, at his/their 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 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 2018 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. I will notify the school immediately of any changes in information provided on this form.

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, etc. _____

_____

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

_____

5. Please list any allergies_____

_____

6. Please list any medications and dosages taken regularly by your child _____

_____

Father/Guardian Signature_____ **Date**_____

Mother/Guardian Signature_____ **Date**_____

Immanuel Lutheran Christian Academy