Authorization for the Emergency Care of Minor(s)

I/we the undersigned parent/guardian of

_____ _____

Full Name of Minor Child | Birthday of Minor Child

_____ _____

Full Name of Minor Child | Birthday of Minor Child

_____ _____

Full Name of Minor Child | Birthday of Minor Child

In the event that I/we cannot be contacted through reasonable efforts do hereby authorize:

_____ _____

Full Name of Temporary Custodian(s) | Address of Temporary Custodian

_____ _____

Phone Number | Address Continued

The right to seek and consent permission to any examination, x-ray, medical/surgical diagnosis, anesthetic, and/or hospital care to be provided to my/our minor child by a physician, surgeon or dentist licensed to practice in the state of Oklahoma, when the need for treatment is immediate, or deemed necessary by the better judgment of the temporary caregiver and said medical provider. This authorization takes effect for the period of time originating on:

_____ and ending on _____.

I do hereby indemnify and hold harmless any physician, hospital, or other individuals acting in reliance on this authorization.

_____ _____

Signature of Minor Child's Parent/Legal Guardian | Date of Execution

_____ _____

Signature of Minor Child's Parent/Legal Guardian | Date of Execution

_____ _____

Witness | Date of Execution

Important Information

Parent/Guardian can be reached via the following:

Name and phone number for primary care doctor, dentist, specialist(s):

Allergies:

Current Medications:

Special Care Instructions:

Insurance Company:
Insurance Policy Number:

Local Family Member Contact Information:

Further Instructions: