Immunization    EMERGENCY PROCEDURE CARD    "Use Pencil Only"

Completed______ Exempt______    Teacher ____________

PUPIL'S NAME ______________________________________________
Last    First    Middle

ADDRESS ______________________________________________

BIRTHDATE ____________ BIRTH CERTIFICATE # ____________ AGE ______ PHONE ____________

Distance you live from school ____________ Directions to home ______________________

In case of emergency, illness, or accident to the above-named child, the school is authorized to proceed as indicated below. Please check proper lines.

( ) Father's/Guardian's Name ______________________ Phone ____________

( ) Mother's/Guardian's Name ______________________ Phone ____________

( ) Contact family physician ______________________ Phone ____________

( ) Take child to emergency hospital ______________ Licensed Physician ____________

( ) Name and number of persons to call in case of emergency. (other than parents)

1. ______________________ 2. ______________________

Name and grade of students in Moore schools

Name ____________ Grade ______ Name ____________ Grade ______

Name ____________ Grade ______ Name ____________ Grade ______

NOTE: Please list any physical disability and/or drugs child may be sensitive to: ____________

(Explain) ______________________

Parent Signature ______________________

## Authorization for Medical Care of a Minor*

I, ______________________________________________
(Please Print Name)

the undersigned parent or person having legal custody or the legal guardian of

______________________________________________
(Please Print Minor's Name)

DO HEREBY AUTHORIZE ______________________________________________
(Name of Person to Whom Child is Entrusted)

TO CONSENT TO any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care to be rendered to the above named minor under general or special supervision and upon the advice of a physician, surgeon or dentist licensed under the laws of the State of Oklahoma.

IN GIVING THIS CONSENT I RECOGNIZE AND UNDERSTAND that in situations where the above named minor requires immediate medical or hospital care it may not be possible to contact me, and that in such situations I will not be able to knowledgeably evaluate and choose among the available alternative treatments or procedures, if any, or to evaluate the risks attendant upon each, and the risks attendant to foregoing all treatment; in such situations, I authorize a physician, surgeon or dentist to exercise his professional judgement and assess the risks incident to and choose the necessary treatment from any available alternatives and to render such care and perform such treatment as he in his professional judgement determines to be necessary for the health or safety of the above named minor.

______________________________________________
(Date)    (Signature of parent or person having legal custody or legal guardian)

______________________________________________
(Address)    (Telephone)

______________________________________________
(City)    (State)    (Zip)

Treatment Information:

Minor's Birth Date: ______________________

Minor's Doctor (Name and Telephone No.) ______________________

______________________________________________

Minor's Allergies ______________________

Medicine Minor is Taking ______________________

Date of Minor's Last Tetanus Shot ______________________

Minor's Medical History ______________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________
Hospital Emergency Department Preference (if circumstances allow)

*A community service project of Presbyterian Hospital and its affiliated hospitals in Alva, Atoka, Guthrie, Healton, Purcell Sailing, Wetumka and Woodward Presbyterian Hospital, N. E. 13th and N. Lincoln Blvd., Oklahoma City, Ok. 73104 (405) 524-3029