COMPLETE AND SUBMIT TO:
University of Oklahoma
Goddard Health Center
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 Goddard Health Center 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:_____

_____

A photocopy shall be as valid as the original.