Broken Arrow Family Clinic

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, medical or surgical diagnosis or treatment by any physician or nurse practitioner licensed by the State of Oklahoma and hospital service that may be rendered to said minor under the general, specific or special consent of:

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

the temporary Custodian of the minor: whether such diagnosis or treatment is rendered at the office of the physician or nurse practitioner, or at a hospital licensed by the State of Oklahoma. I/We authorize the physician or nurse practitioner to call in any necessary consultants, in his/their discretion. We further authorize said physician or nurse practitioner 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 nurse practitioner to exercise his/their best judgment as to the requirements of such diagnosis or medical or surgical treatment.

This consent shall remain effective until_____ a.m./p.m. on the _____ day

of _____, 20____ unless sooner revoked in writing, delivered to said physician or nurse practitioner or to said persons entrusted with the custody, care and control of said minor child or children.

Parent/Legal Guardian _____ Date:_____

Witness: (other than Custodian(s) _____