Immunization Complete ☐ Exempt ☐

EMERGENCY PROCEDURE CARD

Pupil Name _____

Address _____ **City** _____ **State** _____ **Zip** _____

Birth Date _____ **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 the 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/guardians)

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 _____

I, _____

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

_____

DO HEREBY AUTHORIZE _____

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 knowledgably evaluate the risks attendant upon each, and 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 judgment 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 judgment determines to be necessary for the health and safety of the above named minor.

Date _____ **Guardian Signature** _____

Address _____ **Phone** _____

City _____ **State** _____ **Zip** _____

Treatment information

Minor's Birth Date _____

Minor's Doctor (Name and Number) _____

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, Healdton, Purcell, Seiling, Wetumka and Woodward Presbyterian Hospital, NE 13th and North Lincoln Blvd. Oklahoma City, OK 73104 (405)524-2029**