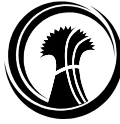

Oklahoma Academy

Consent to Treat Form

CONTINUING CONSENT TO TREATMENT AND
AUTHORIZING TO RELEASE INFORMATION

We, the undersigned parents or guardians of __________________________ do hereby consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instructions of any physician the school or organization may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that reasonable effort will be made to contact us as the parents before medical treatment. It is further understood that we will be billed directly by the doctor.

It is further understood that this consent is given before any specific diagnosis or treatment might be required, and is given to authorize OKLAHOMA ACADEMY or the physician to exercise their best judgment as the requirements of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to the school or organization entrusted with the custody of said minor.

We hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to OKLAHOMA ACADEMY or its representative, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Parent's Name: ____________________________

Address: ___________________________________ Parent's Social Security Number: ____________________________

____ Student's Social Security Number: ____________________________

____ Parent's signature: ____

Home Phone #: ____________________________ Legal Guardian signature: ___________________________________

Work Phone #: ____________________________ Student's DOB: ____

THIS PERMISSION TO TREAT MUST BE NOTARIZED IN ORDER TO BE VALID.

State of ____

County of ____

Signed and attested before me on this _____________ day of ____________________ 20 _____ by_______________________

____ Notary

My commission expires ___________________________

Known allergies to medications are listed here: ____