SaintFrancis Health System

AUTHORIZATION FOR EMERGENCY CARE TO MINOR(S)

987-010C / 09-16

MINOR'S NAME IN FULL	DATE OF BIRTH
MINOR'S NAME IN FULL	DATE OF BIRTH
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NAME OF ADULT PERSON WHO IS TEMPORARY CUSTODIAN OF MINOR

I/we, the undersigned spouse, parent(s) or legal guardian of the minor(s) listed above, do hereby authorize any x-ray examination, anesthetic, dental, medical or surgical diagnosis or treatment by any physician or dentist licensed by the state of Oklahoma and hospital service that may be rendered to said minor under the general, specific or special consent of the temporary custodian of the minor; whether such diagnosis or treatment is rendered at the office of the physician or dentist, or at a hospital licensed by the state of Oklahoma. I/we authorize the physician or dentist to call in any necessary consultants, in his/their discretion. We further authorize said physician or dentist 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 dentist to exercise his/their best judgment as to the requirements of such diagnosis of medical, dental 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 dentist or said persons entrusted with the custody, care and control of said minor child or children.

SIGNATURE - SPOUSE *(IF ANY)*	DATE	TIME
SIGNATURE - FATHER	DATE	TIME
SIGNATURE - MOTHER	DATE	TIME
SIGNATURE - LEGAL GUARDIAN	DATE	TIME
WITNESS - *OTHER THAN CUSTODIAN(S)*	DATE	TIME