Arkansas-Oklahoma Synod
Authorization for Medical Care of Participant

Event: _____

I, _____, the undersigned parent or person having legal custody or the guardian of _____, DO HEREBYAUTHORIZE _____ TO CONSENT to any x-ray examinations, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care to be rendered to the above named participant under general or special supervision and upon advice of a physician, surgeon or dentist licensed under the laws of the states of Arkansas and 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. In such situations, I will not be able to knowledgeably evaluate 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/her 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/she in his/her professional judgement determines to be necessary for the health and safety of the above named participant.

I also understand this covers consent for all activities for the above named participant through the Arkansas-Oklahoma Synod Lutheran Youth Organization.

_____

Signature **Date**

Address:_____

City: _____ **ST:** _____ **Zip Code:** _____

Home phone: _____**Work phone:** _____

Cell phone: _____

Emergency contact name: _____ **Phone:** _____

Treatment Information

Insurance carrier's name: _____ **Policy number:** _____

Insured's name & relationship to minor: _____

_____

Physician's name: _____

Physician's phone number: _____

Participant's birthdate: _____ **Date of last Tetanus shot:** _____

List any known allergies and reactions: _____

_____

List medications participant is currently taking including frequency: _____

_____

Participant's pertinent medical history: _____

_____

_____

_____

_____

++End of Medical Authorization +++