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“Preserving the Osage Language one child at a time”

AUTHORIZATION FORM

Form type: _____ New _____ Update Date Completed: _____

Student Name: _____ Site: _____

I. Pick-Up Authorization

Name	Relationship

II. Prohibited for Pick-Up

Name	Relationship

**If a parent is listed, please attach a copy of visitation order, custody order, or protective/restraining order.*

III. Screening/Assessment Authorization

ՃԼԲՕՏԿԼ Ա՚ԿՕԾԼԲՈՆ offers the following health screenings. By checking the boxes below, you give consent to Academy staff and/or health care professionals to conduct the screenings.

Vision	Hearing	Growth
Physical	Speech/Language	Developmental
Mental Health	Osage Language	Dental

IV. Medical Authorization

Please Initial

_____ In case of emergency, I authorize ՃԼԲՕՏԿԼ Ա՚ԿՕԾԼԲՈՆ staff to seek medical/dental treatment for my student from a qualified doctor, dentist, emergency room, EMT, clinic or other medical facility.

_____ In case of emergency, I authorize ՃԼԲՕՏԿԼ Ա՚ԿՕԾԼԲՈՆ staff to administer basic first aid to my student while in Academy care should an injury occur.

V. Release of Information Authorization

Please Initial

_____ I authorize Osage Nation WIC to release pertinent health information regarding my student to ՃԼԲՕՏԿԼ Ա՚ԿՕԾԼԲՈՆ.

Name of Parent/Guardian:	Last	First	MI	
Address:	Street	City	State	Zip
Phone:				

Parent/Guardian Signature

Date