AUTHORIZATION FOR TREATMENT TO MINORS

I/We the undersigned, parent(s) or legal guardian of the minor listed below:

_____ Birth Date: _____

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:

Miss Oklahoma's Outstanding Teen Organization, Linda Woodard
(Name of Organization/person who is temporary custodian of the minor)

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, at 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 or medical or dental or surgical treatment.

This consent shall remain effective until 12:00 midnight on the 8th day of June, 2018, 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.

_____ _____
Date Parent/Legal Guardian Signature

_____ _____
Date Teen Contestant Signature

DO NOT MAIL – PLEASE BRING TO CHECK-IN
DUE: JUNE 4, 2018 – BRING TO CHECK-IN

HEALTH HISTORY AND PARENTAL CONSENT FORM

DUE: JUNE 4, 2018 – DO NOT SEND EARLY – BRING TO CHECK-IN

_____ **FEMALE** _____

Last **First** **Sex** **Parent or Guardian**

_____

Home Address **City / State/ Zip Code**

_____ _____ _____

Age **Date of Birth** **Social Security Number**

_____ _____ _____ _____

Area Code **Home Phone** **Father cell phone** **Mother cell phone**

Parent(s) arrival date in Tulsa: _____

_____

Name of Hotel **Phone Number**

While in Tulsa, in case of an emergency please contact: _____

Name **Phone**

HEALTH HISTORY

Question:	Yes	No	Explain any Yes answers
Chronic and/or recurrent illness?			
Hospitalizations?			
Operations?			
Taking Medications?			
Organ Missing?			
Diabetes/Blood Sugar Disorders?			
Dizziness, Fainting, Epilepsy, Seizures?			
Allergies/Asthma?			
Migraine Headaches?			
Concussion?			
Wear Glasses/Contacts?			
Hearing Problems?			
Allergic to medications?			
High Blood Pressure?			
Bone, Joint, Spine injury?			
Liver, spleen, Kidney, or Skin?			

Blood Type: _____ (it is mandatory that we have this information)

Primary Physicians Name **Phone Number**

Insurance Company **Group Number** **Phone Number**

*** * PLEASE ATTACH A COPY OF ALL INSURANCE AND DENTAL CARDS * ***

The applicant is under the care of a physician for the following condition(s):

Current treatment (include current medications):

Please give any additional concerning health history:

Please list any medication(s) that you are taking at this time:

The above information is correct to the best of my knowledge. I hereby give my informed consent for the above mention contestant to participate in all activities.

Signature of Parent/Legal Guardian **Date**