TULSA PUBLIC SCHOOLS
HEALTH SERVICES

AMBULANCE TRANSPORT:
EMERGENCY MEDICAL INFORMATION
AND AUTHORIZATION TO TREAT & TRANSPORT A MINOR

THIS INFORMATION IS REQUESTED TO ASSIST THE AMBULANCE PERSONNEL IN PROVIDING APPROPRIATE CARE TO THE ABOVE NAMED STUDENT. THE INFORMATION WILL BE RELEASED ONLY TO INDIVIDUALS PROVIDING MEDICAL CARE.

STUDENT'S NAME: _____ BIRTH DATE: _____
ADDRESS/CITY/ZIP: _____
TELEPHONE #: _____ SOC. SEC #: _____

NAME OF PARENT/LEGAL GUARDIAN OR PERSON RESPONSIBLE FOR STUDENT'S CARE:
_____ RELATION: _____
ADDRESS (IF DIFFERENT FROM STUDENT): _____
DAYTIME PHONE #: _____ SOC. SEC #: _____

MEDICAL COVERAGE (CHECK ALL THAT APPLY):
(Note: This does NOT affect the medical care needed)

NONE _____	PRIVATE INSURANCE _____	MEDICAID/ STATE AID _____	EMSA TOTAL CARE _____

INSURANCE CARRIER: _____ POLICY #: _____
MEDICAID # OR SSI #: _____ TOTAL CARE #: _____

STUDENT'S PRIMARY CARE
PHYSICIAN: _____ HOSPITAL PREFERENCE: _____

STUDENT'S ALLERGIES: _____ NONE KNOWN: _____

MEDICAL CONDITION/PAST MEDICAL HISTORY: _____
_____

CURRENT MEDICATIONS & DOSAGES: _____

_____

FOR THE SCHOOL NURSE/OFFICE STAFF

Today's Date: _____

PLEASE NOTE THE PRESENTING PROBLEM OR REPORTED REASON WHICH LED TO CALLING FOR AN AMBULANCE. FOR MEDICAL PROBLEMS, LIST THE SIGNS & SYMPTOMS AND THE TIME OF ONSET. FOR INJURIES, DESCRIBE THE EVENTS PRECEDING THE INJURY, AND ANY WOUNDS OR SIGNS NOTED. IF VITAL SIGNS ARE AVAILABLE, PLEASE INCLUDE THEM HERE WITH THE TIME TAKEN.
THANK YOU!

_____
_____
_____

(over)

EMERGENCY MEDICAL INFORMATION
AND AUTHORIZATION TO TREAT & TRANSPORT A MINOR

AUTHORIZATION FOR EMERGENCY CARE TO MINOR

I/We the undersigned, parent(s), legal guardian, or person responsible for student's care of the minor children listed below:

Minor's Name _____Birth Date:_____

do hereby authorize ambulance transport by an ambulance service licensed by the State of Oklahoma; and do hereby authorize an 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 a Tulsa Public Schools designated staff member or school nurse, the temporary custodian of said 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 further authorize said physician or dentist to exercise his/her 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/her best judgment as to the requirements of such diagnosis or medical or dental or surgical treatment.

This consent shall remain effective until _____am/pm on the _____ day of _____, _____, unless sooner revoked in writing, delivered to said physician or dentist or said person entrusted with the custody, care and control of said minor child.

_____ _____
Signature of Parent/Legal Guardian or Person Responsible for Student's Care — Date

_____ _____
Signature of Parent/Legal Guardian or Person Responsible for Student's Care — Date

_____ _____
Witness (Other than individuals identified above) — Date

*This form must be reviewed and updated each school year.

HD 38C 07/94