# 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 Creek County Pageant – Shannon Nation, Julie Enlow, Deidra Stobaugh or Wendi White

(Name of organization/person who is temporary custodian of the minor)

In 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 8:00 p.m. on the 22nd day of September, 2015, 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: _____ _____
Father

Witness: Other than Custodian(s) _____
Mother

_____ _____
Legal Guardian

**DO NOT MAIL – PLEASE BRING TO CHECK-IN**

2006mop/Healthform

**Due: Sept 19, 2015, bring to check-in.**

# Health History and Parental Consent Form

Due September 19, 2015. **DO NOT SEND EARLY**!

_____ _Female_ _____

Name: Last First Sex Parent or Guardian

_____

Home address City / State / Zip Code

_____ _____ _____

Age Date of Birth Social Security Number

_____ _____ _____ _____

Area Code Home Phone: Father work/cell phone: Mother work/cell phone:

Parents arrival date in Sapulpa: _____

_____

Name of Hotel Phone Numbers:

While in Sapulpa, 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:_____ Area Code:_____ Phone: _____

Insurance Company Group Number Area Code: Phone:

***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 information 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. AUTHORIZATION FOR TREMENT: I hereby give permission to the medical personnel selected by the Miss Creek County Pageant to order X-rays, routine tests, treatment, and necessary transportation. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Miss Creek County Pageant to secure and administer treatment, including hospitalization, for my child as named above. I understand that contestants are responsible for all medical/dental expenses incurred during the time they participate in the Miss Creek County competition activities and that neither the Miss Oklahoma Organization nor its medical insurance plan will be responsible for any such expenses.

X_____ Date:_____

Signature of Parent or Guardian