# OASC Health Form

## AUTHORIZATION FOR EMERGENCY CARE

We the undersigned, parents or legal guardians of the student listed below:

_____ Birth Date_____

(Student Name PRINTED) (Month/Day/Year)

Do hereby authorize the OASC staff to consent to any emergency treatment by any physician, surgeon or dentist licensed by the State of Oklahoma to any hospital care that may be render to said person, whether such diagnosis or treatment is rendered at the office of a physician, surgeon or dentist at a hospital licensed by the State of Oklahoma. I further agree to release the OASC staff and hold them harmless from any damages that might arise from his actions in consenting to any medical, dental, or hospital care rendered to the above named minor. The consent shall remain in effect until the conclusion of the OASC BASIC or Advanced leadership workshop unless sooner revoked in writing delivered to the OASC staff, and the physician, surgeon or dentist

The following basic medications will be provided and administered by an OASC advisor/staff person, as needed. **Please make a check mark by the medication(s) we have your permission to administer to your child**. We will follow the recommended dosage on the package unless otherwise noted by you. If there is another over-the-counter medication that you would rather have your child take, you will need to supply that medicine, in its original container placed in a Ziploc bag with any other medications your child brings. If your child has an inhaler, it needs to be carried with him/her at all times.

_____Acetaminophen _____ Ibuprofen _____Antihistamine

_____Anti-diarrheal _____ Antibiotic Ointment _____Cough Drops

_____ _____ _____

(Parent's Name printed) (Parent's Signature)

Parent Numbers: Home_____ Work_____ Cell_____

Parent/Guardian/Relative: Name_____ Work_____ Cell_____

Family Doctor_____Office number_____

Health Insurance Company_____ Policy #_____

Any prescription medications he/she will be self administering? (Medication must be in its original container with full information/instructions.)

_____

Any allergies/conditions that would be helpful for the workshop staff to be aware of. Please be specific.

_____

I have been vaccinated for Covid-19: (please complete this section and provide a copy of vaccination with your registration form, if applicable)

| Manufacturer | First Dose Date | Second Dose Date |
|---|---|---|
| Pfizer | | |
| Moderna | | |
| Johnson & Johnson | | ` |