TULSA PUBLIC SCHOOLS
HEALTH SERVICES

EMPLOYEE AMBULANCE TRANSPORT: EMERGENCY MEDICAL INFORMATION AND AUTHORIZATION TO TREAT & TRANSPORT

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

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

PERSON TO CONTACT IN AN EMERGENCY: _____ RELATION: _____
DAYTIME PHONE: _____

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 #: _____

PRIMARY CARE PHYSICIAN: _____ HOSPITAL PREFERENCE: _____

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)

EMPLOYEE AMBULANCE TRANSPORT:
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I, _____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 me under the general, specific or special consent of a Tulsa Public Schools designated staff member or school nurse; 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 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 listed above, 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.

_____ _____
Employee Signature Date

_____ _____
Witness (Other than individuals identified above) Date

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

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