Oklahoma House of Representatives
Page Medical Treatment Authorization Form

Instructions: Please complete the information, as requested. Email the completed and signed form to your Representative, no later than two weeks prior to your service.

THIS FORM AUTHORIZES EMERGENCY MEDICAL TREATMENT FOR:

_____ _____/_____/_____
(Page's name, please print) Date of Birth

FOR THE FOLLOWING PERIOD OF TIME: _____/_____/_____ THROUGH _____/_____/_____
(Dates of Page Service)

WHILE SERVING AS A PAGE FOR REPRESENTATIVE(name of House member)_____

PLEASE LIST:

Current medications: **Reasons for taking this medication:**

1. _____ _____
2. _____ _____

Allergies: _____, _____, _____

Brief history of illnesses/surgeries:

1. _____
2. _____
3. _____

Physician information:

Name: _____ City: _____ Phone Number: (_____)_____-_____

INSURANCE COVERAGE:

Company: _____ Policy Number: _____

Name of person listed as the primary holder of this insurance coverage: _____

Telephone numbers where parent(s) or guardian may be reached, day or night:

Relationship to Page	Work Phone	Home Phone	Cellular Telephone	Pager
1._____	(____)_____-_____	(____)_____-_____	(____)_____-_____	(____)_____-_____
2._____	(____)_____-_____	(____)_____-_____	(____)_____-_____	(____)_____-_____
3._____	(____)_____-_____	(____)_____-_____	(____)_____-_____	(____)_____-_____

_____ _____
Signature of Parent(s) or Guardian(s) Date

_____

Dates of Page Service

PLEASE USE THIS SIDE OF THE MEDICAL TREATMENT AUTHORIZATION FORM TO LIST ANY INFORMATION WHICH WOULD NOT FIT ON THE REVERSE SIDE

Current medications: **Reasons for taking this medication:**

3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

Allergies: _____, _____, _____

_____, _____, _____

Brief history of illnesses/surgeries:

4. _____
5. _____
6. _____

Telephone numbers where parent(s) or guardian may be reached, day or night:

Relationship to Page	Work Phone	Home Phone	Cellular Telephone	Pager
1._____	(____)_____-_____	(____)_____-_____	(____)_____-_____	(____)_____-_____
2._____	(____)_____-_____	(____)_____-_____	(____)_____-_____	(____)_____-_____
3._____	(____)_____-_____	(____)_____-_____	(____)_____-_____	(____)_____-_____

_____ _____
Signature of Parent(s) or Guardian(s) Date

(If you have added information to this side of the Medical Release Form, please be sure to sign and date this side)