Oklahoma House of Representatives
Intern Medical Treatment Authorization Form

Instructions: Bring the completed and signed form when reporting for service.

THIS FORM AUTHORIZES EMERGENCY MEDICAL TREATMENT FOR: _____ / ___ / ___ Social Security No.

_____ ___ / ____ / ___ Date of Birth
(Intern's name, please print)

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

WHILE SERVING AS AN INTERN FOR THE OKLAHOMA HOUSE OF REPRESENTATIVES.

PLEASE LIST:

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

1. _____ _____
2. _____ _____

(If there are more medications, please note on the reverse of this form)

Allergies: _____, _____, _____

(If there are more allergies, please note on the reverse of this form)

Brief history of illnesses/surgeries:

1. _____
2. _____
3. _____

(If more room is needed to list important information, please note on the reverse of this form)

Intern's 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), guardian or next of kin may be reached, day or night:

	Relationship to Intern	Work Phone	Home Phone	Cellular Telephone
1	_____	(___) ____ - _____	(___) ____ - _____	(___) ____ - _____
2	_____	(___) ____ - _____	(___) ____ - _____	(___) ____ - _____
3	_____	(___) ____ - _____	(___) ____ - _____	(___) ____ - _____

(If more room needed to list this important information, please note on the reverse of this form)

_____ _____
Signature of Participant or Parent(s) or Guardian(s) if under 18 — Date

__ _____
Dates of Intern 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 _____

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

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

_____ _____
Signature of Parent(s) or Guardian(s) Date
Parent(s) or Guardian(s) if under 18

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