



CONSENT FOR MEDICAL TREATMENT OF A MINOR

As a parent or guardian a potential problem exists in the event your child requires medical treatment and you are not available to give consent. In order to avoid possible delays in necessary treatment as a result of not being able to contact you, your signature on this completed form will provide the hospital with written consent to provide immediate treatment.

Child's Name _____ Age _____ Birthdate _____

Medications Child Is Taking _____

Allergies (include all known allergies, i.e. food, drugs) _____

Special Medical Problems (include heart, lung, diabetes history)) _____

Date of Last Tetanus _____ Are immunizations up-to-date? Yes No

Name of Parent/Guardian _____ Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Name of Spouse _____ Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Family Physician _____ Office Phone _____

Emergency Number and Other Person to Contact _____

Hospital Preference _____

Insurance Company _____ Policy Number _____

Policy Holder _____

Medical Treatment Authorization/Release of Liability: In case of medical need involving the minor listed, I request that the hospital staff to contact me (or my spouse) at the numbers provided. In the event that I (or my spouse) cannot be reached, I grant permission to the hospital's emergency medical staff to render medical care as deemed appropriate. The authorization shall remain in effect until cancellation in writing, and must be updated annually.

Mother's/Guardian Signature

Father's/Guardian Signature