



## CONSENT FOR MEDICAL TREATMENT OF A MINOR 2023-2024

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