

CONSENT FOR MEDICAL TREATMENT OF A MINOR 2024-2025

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				
Special Medical Problems (inc	lude heart, lung, o	diabetes his	story))	
Date of Last Tetanus	Are	 e immuniza	ations up-to-date?	 1 No
Name of Parent/Guardian		Ad	dress	
Home Phone	Work Phone _		Cell Phone	
Name of Spouse	A	ddress		
Home Phone	Work Phone _		Cell Phone	
Family Physician	Office Phone			
Emergency Number and Other	Person to Contac	t		
Hospital Preference				
	Policy Number			
Policy Holder				
listed, I request that the hosp the event that I (or my spouse medical staff to render medic effect until cancellation in wr	oital staff to contage) cannot be reach cal care as deemed riting, and must be	ct me (or n ed, I grant I appropria e updated a	ase of medical need involving ny spouse) at the numbers propermission to the hospital's etc. The authorization shall renannually.	vided. In emergency nain in
Mother's/Guardian Signature	gnature	Fat	her's/Guardian Signature	