# 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 _____

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