Consent for Medical Treatment

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 treatment as a result of not being ablet o contact you, your signature on this completed form will provide the hospital with written consent to provide immediate treatment.

Child's Name ____ Birthday ___________________

Allergies ____

Regular Medications ____

Special Needs or Medical Problems ____

Are immunizations up to date? Yes No Date of Last Tetanus__________________

Name of Parent/Guardian #1 ____

Address ____

Home Phone ________________ Work Phone _________________ Cell Phone _________________

Physician ______________ Office Phone _____________ Hospital Preference __________________

Emergency Contacts (other than parents)

Name ____ Phone _____________________________

Name ____ Phone _____________________________

Insurance Company ______________ Policy Number ____________ Policy Holder ______________

MEDICAL TREATMENT AUTHORIZATION: In case of medical need involving the minor listed, I request the hospital staff to contact the parents/guardians listed above at the numbers provided. In the event that we cannot be reached, I grant written permission to my child's physician or the hospital's emergency medical staff to render medical care as deemed appropriate. I agree to pay for normal and customary charges of the hospital for any treatment or medication received by said child. I also agree to notify the hospital in writing if I cease to be guardian or if there are any changes in the above authorization.

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Parent/Guardian Signature Date

This authorization remains in effect until written cancellation is received by the hospital.

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