# CONSENT FOR MEDICAL TREATMENT OF MINOR

As a parent/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 delays in necessary treatment as a result of not being able to contact you, your signature on this completed form will provide hospital written consent to provide immediate treatment.

Child's name _____ Age _____ Birth date _____

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 _____

Home Phone _____ Address

Work Phone _____ _____

Work Hours _____ _____

Cell Phone _____

Name of Spouse _____

Work Phone _____ Address (if different from above)

Work Hours _____ _____

Cell Phone _____ _____

Physician Name _____ Office Phone _____

Insurance Company _____

Policy Number _____ Policy Holder _____

Emergency number and other person to contact _____

_____

**MEDICAL TREATMENT AUTHORIZATION: In case of medical need involving the minor listed, I request 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 written permission to my physician or the hospital's emergency staff to render medical care as deemed appropriate. I (we) agree to pay normal and customary charges of the hospital for any treatment or medication received by said minor. 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.**

_____

Mother/Guardian Signature Father/Guardian Signature Date

**THIS AUTHORIZATION REMAINS IN EFFECT UNTIL WRITTEN CANCELLATION IS RECEIVED BY THE HOSPITAL.**