CONSENT FOR MEDICAL/SURGICAL CARE/EMERGENCY TREATMENT AND CHILD'S MEDICAL INFORMATION

In presenting my child for diagnosis and treatment, I, _____, the parent and/or legal guardian for _____ of _____ years of age, hereby voluntarily consent to the rendering of such care; including diagnostic procedures, surgical and medical treatment, and blood transfusions, by authorized members of the hospital staff or their designees, as may in their professional judgment be necessary. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on child's condition.

(Mother, Father or Legal Guardian)

(Child's Name)

(Age)

I hereby give my consent to: _____, who will be caring for my child named above, for the period of _____ to _____ to arrange for routine or emergency medical/dental care and treatment necessary to preserve the health of my child.

(Name of Person/Agency)

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period. I have read this form and I certify that I understand its contents.

Name: _____
(Father, Mother, or Legal Guardian)

Address: _____

Pediatrician: _____

Other physicians or specialists, if any: _____

Child's Allergies, if any: _____

Date of last tetanus booster: _____/ _____/ _____

Medicines child is taking: _____

Parent/Guardian Contact Numbers

Home Phone: (___) _____-_____

Work Phone: (___) _____-_____ X _____

Cell Phone1: (___) _____-_____

Cell Phone2: (___) _____-_____

Hotel: _____

Restaurant: _____

Other: _____

Name of Health Insurance Company(s): _____

Group or Agreement #: _____ Policy #: _____

Additional Comments: _____

Signature: _____ Date: _____/ _____/ _____
(Father, Mother, or Legal Guardian)

Witness: _____ Date: _____/ _____/ _____

Adapted from: American College of Emergency Physicians

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----------For Hospital/Physician Use----------

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