Parental Consent for Medical Treatment

Child's Information

_____ _____
Child's Name Date of Birth

_____ _____
Home Address Home Phone Number

_____
City, State, Zip Code

_____ _____
Parental Contact Phone Number

Caregiver Information

_____ _____
Caregiver's Name Phone Number

The above named caregiver shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures (including administration of anesthesia, blood transfusions, diagnostic tests, etc.), for the above named child, which may be required during my absence. If circumstances permit, I would like to have our doctor consulter in connection with such treatment.

Please attempt to contact me at the following telephone number: _____

This consent serves as permission for treatment by _____ (Hospital Name). Note: Consents are not required in emergency situations. I agree to pay for all services provided to my child in my absence. This authorization shall be effective until: (select one)

a) _____ (Month, Day Year) b) unless earlier revoked by me.

Signatures

_____
Parent/Guardian (circle one) Date

_____
Parent/Guardian (circle one) Date

_____
Witness Date

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Family Physician Information

Name _____ Phone Number _____

Address _____

Insurance Information

Company Name _____ Policy Number _____

Medical Information Please print and be thorough.

Chronic or existing medical conditions
(E.G., Asthma, Seizures, Diabetes)

_____

_____

Known Allergies

Anesthetics
Aspirin
Codeine
Demerol
Antibiotics (Please List)

Insect Stings
I.V.P. Dyes
Morphine
Novocaine

Penicillin
Shellfish
Tetanus Toxoid

_____

Other (Please List)

_____

Current Daily Medications

_____

_____

Recent Shots and Vaccines

Tetanus/Date _____

Other/Date _____

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