Parent/Legal Guardian Authorization for Medical Care for Child

Name of Child: ___________________________________

Date of Birth: ____________________________________

I (We) ________________________________
Parent/Legal Guardian

Grant __________________________________
Person Accompanying Child

permission to seek medical care and consent to treatment as deemed necessary to the above named dependant in my absence. The care will be given at the office of ______________________________.
Name of Physician and/or Practice

Parent/Legal Guardian Signature: ______________________________

Date: ______________________________

When you go away, Protect your children

Although you probably have someone to care for your children when you're going away, it's a good idea to make sure their healthcare needs are taken care of, too.

By completing this form and providing all the proper signatures, you are granting permission for Community Hospital and our medical staff to provide medical assistance to your child when that child is under someone else's care.

You must complete a separate form for each child. Then, provide copies of the form(s) to every person who is responsible for the care of your child. Also, remember to send along a form when your child is going away, whether it's to travel, go to camp, or other circumstances.

PLEASE NOTE: The emergency department physician has discretion regarding certain medical procedures, and may require direct parental consent before performing these procedures.

CONSENT FOR TREATMENT

Child's Name:_______________________________ Date of Birth:____________

To Whom It May Concern (please print clearly)

I (We) ____
Parent/Guardian

of _______________________, _______________________, _______________________,
City County State

grant permission for Community Hospital Emergency Department to provide medical care as deemed necessary to the above named dependent while being cared for by

____
name

effective from ___________________ through ________________________
date date

Insurance Company
Company Name:_______________________

I.D. (policy) number:___________________

Family Physician
Name: _________________________

Address:_______________________
____

Phone number:__________________

Signature (must be completed)

____
Parent/Guardian Date

MEDICAL INFORMATION

Any Chronic or Existing Medical Conditions (i.e., hemophilia, epilepsy, diabetes)

____
____
____
____

Blood Type (if known)

- ☐ O
- ☐ A
- ☐ B
- ☐ AB

- ☐ Positive
- ☐ Negative

Know Allergies

- ☐ Anesthetics
- ☐ Antibiotics

____
____
____

- ☐ Aspirin
- ☐ Codeine
- ☐ Cortisone
- ☐ Demerol
- ☐ Insect Stings
- ☐ I.V.P. Dyes
- ☐ Morphine
- ☐ Novacaine
- ☐ Tetanus Toxoid
- ☐ Other________

____
____

Recent Shots and Vaccines

Tetanus/Date:________________

DPT/Date:________________

Other/Date:________________
____

Current Daily Medications (if any)

____
____
____