

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

In presenting my son/daughter for diagnosis and treatment

Name(s): _____

Mother Father Legal Guardian

for _____

Son Daughter

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 designees, as may in their professional judgement 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.

I have read this form and I certify that I understand its contents.

We/I hereby give our (my) consent to:

(Name of Person/Agency)

who will be caring for our (my) child _____
(Name of Child)

for the period _____ to _____
to arrange for routine or emergency medical/dental care and treatment necessary to preserve the health of our (my) child.

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period.

Name: _____

Address: _____

Telephone: _____

Family Physician: _____

Pediatrician: _____

Surgeon: _____

Orthopedist: _____

Child's Allergies, if any: _____

Date of last tetanus booster _____

Medicines child is taking: _____

Name of Insurance Carrier: _____

Group # _____

Agreement # _____

Signature _____
Mother, Father or Legal Guardian

Date: _____

Witness: _____

Date: _____

In case of emergency I can be reached at: _____

