Parental Consent for Medical Treatment

Child's Information

Name: _____

DOB:_____

Parent information:

Name: _____

Address_____

where parents can be reached:_____

Caregiver Information:

Name: _____

Address_____

where caregiver can be reached:_____

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, mental health services, etc.), for the above named child, which may be required during my absence. If circumstances permit, I would like to have our doctor consulted in connection with such treatment.

This consent serves as permission for treatment by ANY Hospital, emergency room, or medical personnel.

This authorization shall be effective until:_____ , unless earlier revoked by me.

Signatures

_____

Parent/ Date

_____

Witness/ Date

Family Physician Information

Name: _____

Address_____

where Doctor can be reached:_____

Insurance Information **(please attached a copy of your insurance card)**

Company name _____

ID # _____

Group # _____

Phone # _____

Other insurance information: _____

_____

_____

Medical Information

Chronic or existing medical conditions: _____

_____

_____

Current Medications:_____

_____

Known Allergies: _____

_____

Date of Last Tetanus Booster _____

Note: If you have more than one child, each child should have a separate authorization.