

Medical History

Allergies, including allergies to medicines, anesthetic, foods, etc.

Chronic or existing diseases or medical problems (diabetes, epilepsy, etc.)

Medications child is taking (please include dose information)

VACCINES

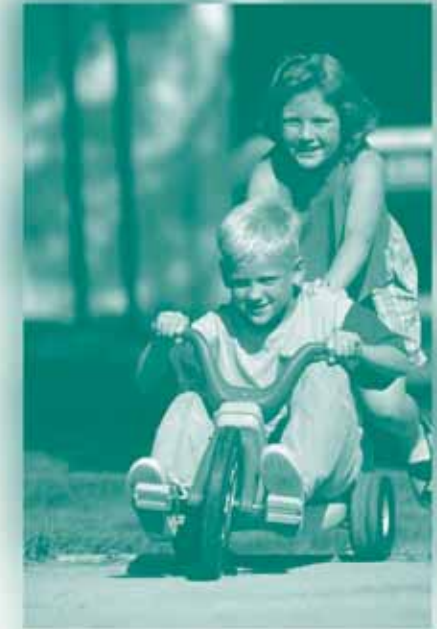
Date of last Tetanus _____

Other _____

*For more copies of this consent form,
call 574/523-3303.*



Protect Your Child While You're Away...



**Consent for
Emergency
Medical
Treatment of a
Minor Child**



▶ Protect Your Child While You're Away...

It is important that you make arrangements for the medical care of your minor child while you are away from home. These arrangements include provisions for prompt emergency medical treatment and care in the event your child is injured or becomes ill.

Unless a child's injuries are life-threatening, physicians and hospital staff need parental or guardian consent. We want to avoid any unnecessary discomfort for your child while waiting for you to be contacted to approve usual and customary medical treatment.

This form allows you to consent to such treatment ahead of time. Simply complete the form—including pertinent data about health insurance coverage and your child's medical history—and give it to the persons who will be responsible for the care of your child while you are away. They can take the completed form with them to the hospital or physician's office of your choice if your child requires immediate medical attention. In some unusual circumstances, it may still be necessary for the physician to contact you directly.

Remember, a separate consent form is needed for each minor child in your family.



Parental Consent for Medical Treatment of a Minor Child

Child's Name _____ Child's Birth Date _____

Home address _____
(street) (city, state, zip)

Parent's/Guardian's Name _____ day ph. _____ evening ph. _____

Parent's/Guardian's Name _____ day ph. _____ evening ph. _____

Home address _____
(street) (city, state, zip)

Alternate phone number (if not at work or home) _____

I (we) the parent(s) or guardian(s) named above, authorize the following adult caregiver to consent to any necessary examination, anesthetic, blood transfusion, medical diagnosis, etc. and/or hospital care to be rendered to the above-named minor child under the general or special supervision and on the advice of any licensed physician. I (we) agree to pay for all services provided to my child in my absence.

Caregiver _____ Phone _____

Address _____
(street) (city, state, zip)

SIGNATURES

Parent or Guardian _____ Date _____

Parent or Guardian _____ Date _____

Witness _____ Date _____

INSURANCE INFORMATION

Insurance Company _____ Member Name _____

Insurance Policy Number _____

PHYSICIANS INFORMATION

Child's Physician _____ Phone _____

Parent's Physician _____ Phone _____