

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

In presenting my son/daughter for diagnosis and treatment;

I, _____ herby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical, medical treatment and blood transfusions by authorized members of the hospital staff or their designees, as may, in their professional judgment, 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 it's contents.

I hereby give my consent to _____,
(Name of Agency)

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

date of birth: _____, for the period _____ until _____ to arrange for routine or emergency medical/surgical/dental care and treatment necessary to preserve the health of my child. I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

Name: _____

Family Physician: _____

Address: _____

Pediatrician: _____

Surgeon: _____

Phone: _____

Orthopedist: _____

Health Insurance Carrier: _____

Child's allergies, if any: _____

ID# _____

Date of last tetanus booster: _____

Group # _____

Medicine child is taking: _____

Signature: _____ Date _____
Parent or Legal Guardian

Witness: _____ Date _____

In case of emergency I can be reached at: _____

Phone: _____