

# Consent for Medical/Surgical Care/Emergency Treatment and Child's Medical Information

In presenting my son/daughter for diagnosis and treatment

Name: \_\_\_\_\_ for \_\_\_\_\_  
 Mother     Father     Legal Guardian                       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 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 my child's condition.

I have read this form and 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: \_\_\_\_\_ Family physician: \_\_\_\_\_

Address: \_\_\_\_\_ Pediatrician: \_\_\_\_\_

\_\_\_\_\_ Surgeon: \_\_\_\_\_

Telephone no.: \_\_\_\_\_ Orthopedist: \_\_\_\_\_

Name of health insurance carrier: \_\_\_\_\_ Child's allergies, if any: \_\_\_\_\_

\_\_\_\_\_

Date of last tetanus booster: \_\_\_\_\_

Group no.: \_\_\_\_\_ Medicines child is taking: \_\_\_\_\_

Agreement no.: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Mother, Father or Legal Guardian*

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

In case of emergency I can be reached at: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_