

WHEN YOU GO AWAY, PROTECT YOUR CHILDREN

Although you probably have someone to care for your children when you're going away, it's a good idea to make sure their healthcare needs are taken care of, too.

By completing this form and providing all the proper signatures, you are granting permission for Community Hospital and our medical staff to provide medical assistance to your child when that child is under someone else's care.

You must complete a separate form for each child. Then, provide copies of the form(s) to every person who is responsible for the care of your child. Also, remember to send along a form when your child is going away, whether it's to travel, go to camp, or other circumstances.

PLEASE NOTE: The emergency department physician has discretion regarding certain medical procedures, and may require direct parental consent before performing these procedures.

CONSENT FOR TREATMENT

Child's Name: _____ Date of Birth: _____

To Whom It May Concern (please print clearly)

I (We) _____
Parent/Guardian

of _____, _____, _____,
City County State

grant permission for Community Hospital Emergency Department to provide medical care as deemed necessary to the above named dependent while being cared for by

name

effective from _____ through _____
date date

Insurance Company
Company Name: _____

Family Physician
Name: _____

I.D. (policy) number: _____

Address: _____

Phone number: _____

Signature (must be completed)

Parent/Guardian Date

MEDICAL INFORMATION

Any Chronic or Existing Medical Conditions (i.e., hemophilia, epilepsy, diabetes)

**Blood Type
(if known)**

- O
- A
- B
- AB

- Positive
- Negative

Know Allergies

- Anesthetics
- Antibiotics
- _____
- _____

- Aspirin
- Codeine
- Cortisone
- Demerol
- Insect Stings
- I.V.P. Dyes
- Morphine
- Novacaine
- Tetanus Toxoid
- Other _____
- _____
- _____

Recent Shots and Vaccines

Tetanus/Date: _____

DPT/Date: _____

Other/Date: _____

Current Daily Medications (if any)



**Parent/Legal Guardian Authorization
for Medical Care for Child**

Name of Child: _____

Date of Birth: _____

I (We) _____

Parent/Legal Guardian

Grant _____

Person Accompanying Child

permission to seek medical care and consent to treatment as deemed necessary to the above named dependant in my absence. The care will be given at the office of _____ Olio Road Family Care _____.

Name of Physician and/or Practice

Parent/Legal Guardian Signature: _____

Date: _____