（様式　Ｐ－５　の裏面）

Information on child

① Birthday

② Allergies

③ Chronic illnesses

④ Regular medication

⑤ Date of last tetanus shot

⑥ Child's physician

⑦ Pysician's phone

⑧ Mother's work phone

⑨ Father's work phone

⑩ Home address

⑪ Home phone

⑫ Insurance co./Policy no.

CONSENT TO MEDICAL CARE AND TREATMENT OF A MINOR

The undersigned authorize all medical,surgical,diagnostic and hospital procedures as may be performed or prescribed by a treating phisician of the hospital for

⑬ _____

(child's name)

if we cannot be reached in the case of any emergency.

Our consent includes, but is not limited to, administration of necessary anesthetics, medical treatment, tests, X-ray examination, transfusions, injections,or drugs and the performing of whatever operations may be deemed necessary or advisable. Further, consent is granted to any such physician to exercise his/her discretion in authorizing the disposal of any severed tissue or members. It is understood this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required. This authorization shall remain in effect until revoked in writing by the undersigned, with notice to the treating physician and hospital, or until the undersigned void their signatures hereon.

⑭ _____ *Date Time(a.m./p.m.)*

⑮ _____ *Signature of father*

⑯ _____ *Witness*

⑰ _____ *Signature of mother*

⑱ _____ *Signature of legal guardian*