

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 physician 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 _____ ⑮ _____
Date Time(a.m./p.m.) *Signature of father*
- ⑯ _____ ⑰ _____
Witness *Signature of mother*
- ⑱ _____
Signature of legal guardian