



EMERGENCY MEDICAL TREATMENT FOR MINOR CHILDREN CONSENT FORM

Community Memorial Hospital

Accidents or sudden illness involving a child or adolescent can occur at any time and place. Unfortunately, parents or guardians are not always immediately available to give hospital emergency staff important health information about their child and the legal permission needed to provide the necessary medical treatment.

This consent form enables healthcare professionals to treat your child for minor emergencies when, and only when, you cannot be notified. This form not only provides permission, but also supplies valuable health facts about your child. You can also use the form to inform hospital staff members about approaches they can take to help comfort your child.

Complete this form and give it to your babysitter, childcare provider, or to the person responsible for your child during times when you are not available, including times when your child is going to camp or traveling with someone else. Of course, if an emergency is life threatening, or if the child might develop complications, treatment would begin immediately, with or without a consent form.

CONSENT FOR EMERGENCY MEDICAL TREATMENT OF A MINOR CHILD

Child's Last Name Child's First Name Child's Middle Initial Child's Nickname

Child's Date of Birth Child's Gender Child's Blood Type

AUTHORIZATION FOR CARE

I/we _____ of
Name or names of parent(s)/legal guardian(s)

Street Address City State Zip Code

hereby state that I am/we are the ___ parent(s) ___ legal guardian(s) (please check one)
of the above named child and that I/we authorize any necessary emergency medical
treatment for my/our child while being cared for by:

Name(s) of caregiver(s)

Street Address City, State, Zip Code Telephone #

for the following time period: _____ to _____
Month/Date/Year Month/Date/Year

X _____
Signature of Parent/Guardian Date

MEDICAL HISTORY

Child's Physician: _____ Physician Phone: _____

Child's Specialist: _____ Specialist Phone: _____

Child's Dentist: _____ Dentist Phone: _____

Allergies, if any, including any medications: _____

Chronic or existing disease or medical problems: _____

Medicines your child is now taking: _____

Date child received last Tetanus Immunization: _____

MEDICAL INSURANCE

Health Insurance Company: _____

Policy Holder's Name: _____ Date of birth: _____

Policy Holder's Employer: _____

Member ID# _____ Policy/Group # _____

EMERGENCY CONTACT INFORMATION

In an emergency, parents/guardians can be contacted as follows:

Parent/Guardian Name: _____ **Home Phone:** _____

Work Phone: _____ **Cell Phone:** _____

Parent/Guardian Name: _____ **Home Phone:** _____

Work Phone: _____ **Cell Phone:** _____

Additional Contact Name: _____ **Home Phone:** _____

Work Phone: _____ **Cell Phone:** _____

Additional Contact Name: _____ **Home Phone:** _____

Work Phone: _____ **Cell Phone:** _____

OTHER INFORMATION

Please include any other information that may assist us in caring for your child.

Community Memorial Hospital and Family Health Centers of CMH

208 North Columbus Street, Hicksville OH 43526

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