Community Memorial Hospital

EMERGENCY MEDICAL TREATMENT FOR MINOR CHILDREN

CONSENT FORM

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.

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____
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Community Memorial Hospital and Family Health Centers of CMH
208 North Columbus Street, Hicksville OH 43526
419-542-6692 ● www.cmhosp.com