Consent for Medical/Surgical Care/Emergency Treatment and Child's Medical Information

Community Pediatrics

In presenting my son/daughter for diagnosis and treatment

Name: _____ for _____ DOB: _____

☐ Mother ☐ Father ☐ Legal Guardian ☐ Son ☐ Daughter

hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment and immunizations, by authorized members of the clinic or hospital staff or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition.

I have read this form and certify that I understand its contents.

We/I hereby give our (my) consent to:

_____

(Name of Person/Agency)

Relationship to child/person granting permission _____

who will be caring for our (my) child _____ DOB: _____

(Name of Child)

for the period _____ to _____ to arrange for routine or emergency medical/dental care and treatment necessary to preserve the health of our (my) child.

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period.

Name: _____
Address: _____
_____
Telephone no.: _____
Health insurance: _____
Member/subscriber ID: _____
Group #: _____

Family physician: _____
Pediatrician: _____
Surgeon: _____
Orthopedist: _____

Child's allergies, if any: _____
_____
Date of last tetanus booster: _____
Medicines child is taking: _____
_____

Signature: _____ Date: _____

Mother, Father or Legal Guardian

Witness: _____ Date: _____

In case of emergency I can be reached at:

_____
_____
_____

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