Lutheran Health Network
Lutheran Children's Hospital

LutheranChildrensHospital.com

PARENTAL CONSENT FORM

Consent for medical treatment

DID YOU KNOW THAT, IN YOUR ABSENCE, NO ONE CARING FOR YOUR CHILDREN CAN AUTHORIZE MEDICAL CARE WITHOUT YOUR WRITTEN PERMISSION? If you leave your child with a sitter while you are working or traveling, complete this form, have it witnessed and leave it with your caregiver. This will ensure that, in an emergency, your child will receive prompt, necessary medical care even if you are not there. The caregiver should have this form available if a child requires medical treatment without the parent/guardian present.

Make copies of blank form for future use.
Can be used at any healthcare facility.

CALL 911 IN AN EMERGENCY.

I (We), ______________________ (parent/guardian name) and ______________________ (parent/guardian name)

of ______________ (city), ______________ (county), ______________ (state) do hereby state

that I am (we are) the parent(s) or legal guardian(s) of ______________________ (name of child),

a minor, age ______________, born on ______________________,

who resides with me (us) at ______________________ (street address)

______________________ (city, state, zip).

I (we) authorize ______________________ (name of caregiver), an adult

over 18 years of age, who resides at ______________________ (address of caregiver) in the city of

______________________, state of ______________, to consent to any necessary examination, anesthesia, surgery, treatment and/or hospital care to be rendered to the above-named minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the state(s) of ______________________

____

for the period ______________ (specific date) to ______________ (specific date)

Today's date: ______________________

SIGNATURE(S) OF PARENT(S) OR GUARDIAN(S):

______________________ ______________________

Witness: ______________________ Witness: ______________________

PARENT(S)/GUARDIAN(S) CONTACT NUMBERS:

Cell: ______________________
Cell: ______________________

Other: ______________________
Other: ______________________

Child's physician: ______________________
Phone: ______________________

MEDICAL INSURANCE

Insurance name: ______________________
Insurance phone: ______________________
Policyholder's name: ______________________
Identification number: ______________________
Group/policy number: ______________________

Allergies (including medications):
____
____

Chronic/existing diseases or medical problems:
____
____

Medications: ______________________
____

Date of last tetanus injection or booster:
____