Medical History

Allergies, including allergies to medication, anesthetic, foods, etc.

____

____

____

____

Chronic or existing diseases or medical problems (diabetes, epilepsy, etc.)

____

____

____

____

Medications child is taking (please include dose information)

____

____

____

Vaccines

Date of last Tetanus ______________________________

Other Vaccines ______________________________

____

For more copies of this form, download a copy at www.egh.org/emergencyservices.

Elkhart General Hospital
600 East Boulevard | Elkhart, IN 46514
574.294.2621

Memorial Hospital
615 North Michigan Street | South Bend, IN 46601
574.647.7458

©2015 Beacon Health System #16021

Consent for Emergency Medical Treatment of a Minor Child

Protect Your Child While You're Away...

It is important that you make arrangements for the medical care of your minor child while you are away from home. These arrangements include provisions for prompt emergency medical treatment and care in the event your child is injured or becomes ill.

Unless a child's injuries are life-threatening, physicians and hospital staff need parental or guardian consent. We want to avoid any unnecessary discomfort for your child while waiting for you to be contacted to approve usual and customary medical treatment.

This form allows you to consent to such treatment ahead of time. Simply complete the form— including pertinent data about health insurance coverage and your child's medical history—and give it to the persons who will be responsible for the care of your child while you are away. They can take the completed form with them to the hospital or physician's office of your choice if your child requires immediate medical attention. In some unusual circumstances, it may still be necessary for the physician to contact you directly.

Remember, a separate consent form is needed for each minor child in your family.

Parental Consent for Medical Treatment of a Minor Child

Child's Name ______________________ Child's Birth Date ______________

Street Address ______________________ City ______________ State ______ Zip ______

Parent's/Guardian's Name ______________________________________

Street Address ______________________ City ______________ State ______ Zip ______

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Parent's/Guardian's Name ______________________________________

Street Address ______________________ City ______________ State ______ Zip ______

Home Phone ______________ Work Phone ______________ Cell Phone ______________

I (We) the parent(s) or guardian(s) named above, authorize the following adult caregiver to consent to any necessary examination, anesthetic, blood transfusion, medical diagnosis, etc. and/or hospital care to be rendered to the above-named minor child under the general or special supervision and on the advice of any licensed physician. I (We) agree to pay for all services provided to my child in my absence.

Caregiver ______________________________ Phone ______________

Street Address ______________________ City ______________ State ______ Zip ______

Signatures

Parent or Guardian ______________________________ Date ______________

Parent or Guardian ______________________________ Date ______________

Witness ______________________________ Date ______________

Insurance Information

Insurance Company ______________________________ Member Name ______________

Insurance Policy Number ______________________________________

Physicians' Information

Child's Physician ______________________________ Phone ______________

Parent's Physician ______________________________ Phone ______________