Consent for Medical Care and Medical Information

Permission

In our absence during _____ (dates and time period), _____ (name of caregiver) is authorized to present our children, _____ (name of children), for emergency medical attention, including diagnostic procedures, surgical and medical treatment and blood transfusions, by qualified medical personnel as they in their professional judgment determine to be necessary. We acknowledge that we are responsible for reasonable charges in connection with this care.

_____

(Parent's signature)

_____

(Parent's signature)

Date: _____

_____

(Witness' signature)

Date: _____

Medical Information

Our Address: _____

Our Home Phone Number: _____

Mother's Name: _____

Phone at Work: _____

Cellular Phone: _____ Pager: _____

Father's Name: _____

Phone at Work: _____

Cellular Phone: _____ Pager: _____

Pediatrician's Name: _____

Address: _____

Daytime phone: _____

Night/Weekend/Holiday Phone: _____

Dentist's Name: _____

Address: _____

Daytime phone: _____

Night/Weekend/Holiday Phone: _____

Opthalmologist's Name: _____

Address: _____

Daytime Phone: _____

Night/Weekend/Holiday Phone: _____

Insurance Company Name: _____

Group Number: _____

Family ID Number: _____

Child's ID Number (child's name): _____

Child's ID Number (child's name): _____

Child's Name: _____

Birth Date: _____

Allergies (to drugs, insect bites, etc.): _____

_____

Medications Child Is Taking: _____

Dose: _____

Frequency: _____
Dose: _____
Frequency: _____
Dietary Restrictions: _____
_____
Date of Last Tetanus Booster:
_____
History of Serious Illness or Injury (include specialists your child sees):
_____
_____
Illness/Injury: _____ Date: _____
Doctor's Name: _____
Phone: _____
Illness/Injury: _____ Date: _____
Doctor's Name: _____
Phone: _____
Other Important Information (such as child's fears, disabilities, etc.):
_____
_____
_____
Child's Name: _____
Birth Date: _____
Allergies (to drugs, insect bites, etc.): _____
_____
Medications Child Is Taking: _____
Dose: _____
Frequency: _____
Dose: _____
Frequency: _____
Dietary Restrictions: _____
_____
Date of Last Tetanus Booster: _____
History of Serious Illness or Injury (include specialists your child sees):
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Illness/Injury: _____ Date: _____
Doctor's Name: _____
Phone: _____
Illness/Injury: _____ Date: _____
Doctor's Name: _____
Phone: _____
Other Important Information (such as child's fears, disabilities, etc.):
_____
_____
_____
