

## CONSENT FOR MEDICAL TREATMENT AND CHILD'S MEDICAL INFORMATION

I hereby voluntarily consent to the rendering of such care (including diagnostic procedures, surgical and medical treatment and blood transfusions) by authorized members of the 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 examination or treatment on my child's condition.

I have read this form and I certify its contents.

We/I hereby give our (my) consent to Our Mother of Consolation CYO, who will be caring for our (my) child \_\_\_\_\_ for the period of \_\_\_\_\_ to \_\_\_\_\_ to arrange for emergency medical 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: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_ Group Number: \_\_\_\_\_

Agreement Number: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Surgeon: \_\_\_\_\_ Orthopedist: \_\_\_\_\_

Child's Allergies (if any): \_\_\_\_\_

Date of Last Tetanus Booster: \_\_\_\_\_

Medicines Child is currently taking: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Parent/Guardian Signature Date

### Emergency Contact:

\_\_\_\_\_  
Name Relationship telephone number