

## PARENT'S CHECKLIST

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

In presenting my son/daughter for diagnosis and treatment, \_\_\_\_\_  
(Mother, Father, Legal Guardian), for \_\_\_\_\_ (Son/Daughter)  
of \_\_\_\_\_ years of age, 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  
examinations or treatment on the 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) who will be caring for our/my child \_\_\_\_\_  
(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 the care and treatment rendered during this period.

Name: \_\_\_\_\_

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

Telephone: \_\_\_\_\_

Family Physician: \_\_\_\_\_

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

Pediatrician: \_\_\_\_\_

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

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

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

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

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

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

Child's Medical History: \_\_\_\_\_

Medicines Child is Taking: \_\_\_\_\_

Date of last Tetanus Booster: \_\_\_\_\_

Name of Insurance Carrier: \_\_\_\_\_

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

Group #: \_\_\_\_\_

Agreement #: \_\_\_\_\_

Signature: \_\_\_\_\_

Mother, Father or Legal Guardian

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness

Date: \_\_\_\_\_

In case of emergency, I can be reached at: \_\_\_\_\_

\_\_\_\_\_.