CONTACT INFORMATION

CHILD'S NAME:

_____

MOTHER'S (GUARDIAN'S) NAME:

_____

FATHER'S (GUARDIAN'S) NAME:

_____

FAMILY DOCTOR:

_____

EMERGENCY CONTACT #s:

_____

_____

_____

HOME ADDRESS:

_____

_____

_____

MEDICAL INSURANCE CARRIER:

_____

ID #:_____

Member Name: _____

Benefit Code: _____

Account #: _____

MEDICAL HISTORY

ALLERGIES (Including Medications):

_____

_____

_____

TETANUS (Date of Last Booster):

_____

CHRONIC OR EXISTING MEDICAL ISSUES (Diabetes, Epilepsy, etc.):

_____

_____

_____

MEDICATIONS (Date _____):

_____

_____

_____

OTHER NOTES:

_____

_____

_____

_____

_____

Consent for Care of a Minor Child

HOCKING VALLEY
Community Hospital

REGISTRATION DEPARTMENT

601 S.R. 664 North, Logan, OH
(740) 380-8000 • www.hvch.org

Hocking Valley Community Hospital is providing this consent form and medical data questionnaire to help avoid possible delays in obtaining treatment for an ill or injured child.

This form is a consent for care of your minor child, who may become ill or injured when you or a legal guardian is not present. In such a case, a frustrating situation could develop for both the child patient and those responsible for that child's care or treatment.

Think of these examples:

- If a child is injured while in the care of a baby sitter or stepparent and requires medical treatment - ***Neither can be accepted as a "legal" substitute for the parent or guardian.***

- A young adult under the age of 18 traveling alone, becomes ill and is taken to the hospital for treatment - ***This minor cannot legally give consent for treatment.***

To help you and care providers avoid such problems, fill in the information requested and give this folder to the persons who will be responsible for your minor children. If care or treatment is needed, they can take it with them to the hospital or doctor.

If you do not wish to leave a signed consent, please do leave specific information as to where you can be contacted at all times.

CONSENT FOR CARE OF A MINOR CHILD

I (We), _____ and _____
(NAME) (NAME)

of _____, _____, _____, do hereby state
(CITY) (COUNTY) (STATE)

that I am (we are) the parent(s) or legal guardian(s) of _____
(NAME)

a minor, age _____, born _____, who resides with me (us) at
(AGE) (DATE OF BIRTH)

_____
(STREET ADDRESS)

I (We) authorize _____, an adult, who
(NAME)

resides at _____ in the city of _____
(ADDRESS) (CITY)

county of _____, state of _____, to consent to any
(COUNTY) (STATE)

necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to the above-named minor under the special supervision and on the advice of any physician or surgeon licensed to practice medicine in the state(s) of _____.

Dated this _____ day of _____, 20_____.

_____ _____
(SIGNATURE OF PARENT/GUARDIAN) (SIGNATURE OF PARENT/GUARDIAN)

Witness _____ Date _____

Witness _____ Date _____