



# If You're Going Away...

Consent For Medical Treatment  
Of A Minor Child



**Kosciusko Community Hospital**  
*Lutheran Health Network Member*

## If You're Going Away...

You have probably made provisions for someone to care for your children not traveling with you. To help you with these arrangements, KCH is providing this consent form and medical data questionnaire which will be valuable should your child be ill or injured while you are away.

The same thing is true if your child is leaving home—going away to camp or traveling with someone other than yourself. This information will be helpful—maybe even required—to give your child the prompt medical care he or she may need.

After you have entered all the information requested, give this brochure to the person who will be responsible for your child. If care is needed, they can take this form with them to the hospital or physician with permission granted for treatment and health information documented.

Extra copies of this brochure are available. Please update them annually. For more information or to request additional copies, call 574.372.5854.



# Consent For Medical Treatment Of A Minor Child

I/we (name) \_\_\_\_\_

and (name) \_\_\_\_\_

of (city) \_\_\_\_\_

(county) \_\_\_\_\_, (state) \_\_\_\_\_

do hereby state that I/we are the parent(s) or legal guardian(s) of:

(child's name) \_\_\_\_\_

a minor, age \_\_\_\_\_ born on \_\_\_\_\_

who resides with me at (address) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I/we authorize (name) \_\_\_\_\_

an adult who resides at (street address) \_\_\_\_\_

\_\_\_\_\_

in the city of \_\_\_\_\_

county of \_\_\_\_\_, state of \_\_\_\_\_

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

\_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_, year \_\_\_\_\_

\_\_\_\_\_  
(parent/guardian signature)

\_\_\_\_\_  
(parent/guardian signature)

## Family Physician

Name \_\_\_\_\_

Phone \_\_\_\_\_

## Medical Insurance Carrier

Name \_\_\_\_\_

Identification Number \_\_\_\_\_

Member's Name \_\_\_\_\_

Benefit Code \_\_\_\_\_

Account Number \_\_\_\_\_

## Medical History

Allergies, if any including medication(s) \_\_\_\_\_

Tetanus (date of last booster) \_\_\_\_\_

Existing diseases or medical problems \_\_\_\_\_

Medication your child is currently taking \_\_\_\_\_

In an emergency, parents or a responsible relative can be reached as follows

Name/Relation \_\_\_\_\_

Phone \_\_\_\_\_

Name/Relation \_\_\_\_\_

Phone \_\_\_\_\_