If You're Going Away...

Consent For Medical Treatment Of A Minor Child

Lutheran Health Network

Kosciusko Community Hospital

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 _____

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