Parental Consent for Medical Treatment of a Minor Child

To avoid possible delay in providing medical treatment in the event your child becomes ill or injured in your absence, Riverview Health offers this form for medical consent and history. It offers assurance that your minor child will receive prompt, personalized attention if you or a guardian are not immediately available.

Please fill out the following form and provide copies to each person who is responsible for caring for your child. If care or treatment is needed, they can present this information to a physician or healthcare provider. Please note:

- You must complete a separate form for each child and caregiver.
- Please update the information at least every six months.
- If all blanks are not filled out completely, the form may not be considered valid.

Child's name ______________________ Child's birth date ______________

Home address ____
(street) (city, state, ZIP)

Parent's/Guardian's name ____________ day ph.__________evening ph.__________

Parent's/Guardian's name ____________ day ph.__________evening ph.__________

Home address ____
(street) (city, state, ZIP)

Alternate phone number (if not at work or home) ______________________

I (we) the parent(s) or guardian(s) named above, authorize the following adult caregiver to consent to any necessary examination, anesthetic, blood transfusion, medical diagnosis, etc. and/or hospital care to be rendered to the above-named minor child under the general or special supervision and on the advice of any licensed physician. I (we) agree to pay for all services provided to my child in my absence.

Caregiver __________________________ Phone ________________

Signatures

Parent or Guardian ______________________ Date ________________

Parent or Guardian ______________________ Date ________________

Witness __________________________ Date ________________

Insurance Information

Insurance company ______________________ Member name ______________

Insurance policy number ____________________

Physician Information

Child's physician ______________________ Phone ________________

Parent's physician ______________________ Phone ________________

Medical History

Allergies, including allergies to medicines, anesthetic, foods, etc.

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Chronic or existing diseases or medical problems (diabetes, epilepsy, etc.)

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____

____

Medications child is taking (please include dose information)

____

____

Vaccines

Date of last tetanus ________________________

Other ________________________________

Contact

395 Westfield Road
Noblesville, IN 46060
317.773.0760

Physician Referral
317.776.7450