

When you're not there

You have probably made plans for someone to care for your child(ren) when not in your care.

This could be care from a grandparent, daycare providers, or neighbor. To help with these plans, we are providing a consent form and medical data sheet which will be valuable should your child become ill or injured while you're away.

This form can also be used if your child is leaving home, such as going camping or traveling with a friend's family. This information will be helpful—and may be required—to give your child the prompt medical care he or she may need.

After you have completed the information and Consent Information, give this information to those who will be taking care of, and responsible for, your child. If care is needed, they can bring this information to the hospital or doctor's office. This lets the hospital and/or doctor know that you have given permission for your child's care provider to make decisions regarding medical care of your child.

Your child can be left in the care of others with ease of mind that their medical needs can be taken care of should it be necessary.

Note: Please complete a separate form for each child. Thank you.

Copy both sides of
Insurance Card Here:

When You're
Not There . . .




HORIZON
H E A L T H C A R E
Caring Through A Lifetime.

An affiliate of
Fairfield Memorial Hospital.

CONSENT FOR MEDICAL TREATMENT OF A MINOR CHILD

I, We _____ of

(parent (s) or guardian(s) name(s))

(street, address, city, state)

Hereby state I/We are the parent(s) or legal guardian(s) of _____

Child's Name

date of birth _____, a minor who resides with me/us.

I/We hereby authorize the following adults to seek medical services and treatment, whether emergent or routine care, for my/our minor child named above:

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

I/We hereby give written permission and consent for any hospital, clinic, medical facility, medical provider, its employees, agents and members of its medical staff to provide medical services whether emergent, routine medical care, or preventative care. This consent includes treatment to relieve pain. Provider of care maintains right to require presence of parent or legal guardian for participation in the care and treatment plan of the minor child. *Copy of medical insurance card should be attached or copied onto the back of the form before providing to medical facility*

A photocopy of this authorization shall be deemed effective as if it were an original.

This authorization is effective from _____ to _____ but

shall not be valid after one year from date of signing or if minor child becomes emancipated or turns eighteen.

Parent/Guardian Signature(s) : _____

Name _____ Relationship _____

Name _____ Relationship _____

Signed and sworn to before me on: _____, 20 _____

Notary Public: _____

[Affix Notary Stamp]

Information:

Family Doctor: _____

Phone: _____

City/ State: _____

MEDICAL INSURANCE:

Insurance Carrier: _____

Member's Name: _____

Policy Number: _____

MEDICAL HISTORY:

Allergies (including medication allergies): _____

Chronic or Existing Medical Conditions (ex: diabetes, epilepsy) _____

Medicines your child is currently taking: _____

Dietary Restrictions (low fat, lactose intolerant): _____

Date your child last received Tetanus Injection or booster: _____

IN CASE OF EMERGENCY, I (WE) MAY BE REACHED AT:

Location: _____

Phone Number (s): _____

