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.

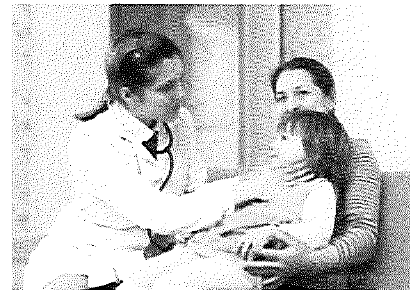
After you have completed the Information and Consent information, give this information to those who will be taking care of , and responsible for, your child. If care is needed, they can bring this information to the hospital or doctor's office. This lets the hospital and/or doctor know that you have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



An affiliate of
Fairfield Memorial Hospital.

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):

____

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]