

**PARENTAL CONSENT FOR EMERGENCY MEDICAL/SURGICAL TREATMENT
AND MEDICAL INFORMATION FORM**

In presenting my (our) child for diagnosis and treatment

Parent Information

Name: _____
Son () Daughter ()

Name: _____

Born _____ ; I/ We as parents/guardians

Address: _____

Name: _____
Mother () Father () Legal Guardian ()

Telephone # _____

Emergency Contact: _____
Phone: _____

hereby voluntarily consent to the rendering of such care and medical treatment, including diagnostic procedures and blood transfusions, by authorized prehospital personnel and members of the hospital staff, as may in their professional judgment be necessary or in the best interest of my child.

Emergency Contact: _____
Phone: _____

Insurance Information

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on child's condition.

Name of Carrier: _____

I have read this form and I certify that I understand its contents.

Policy # _____

In addition I/we hereby give my (our) consent to:

Physician Information

Pediatrician: _____

(Name of person/agency)

Telephone # _____

who will be caring for my (our) Son/Daughter

Family Physician: _____

for the period _____ to _____
to arrange for routine or emergency medical/dental care and treatment necessary to preserve the health of my (our) child.

Telephone # _____

I/we acknowledge that I am (we are) responsible for all reasonable charges in connection with care and treatment rendered during this period.

Surgeon: _____

Signature _____
Mother () Father () Legal Guardian ()

Telephone # _____

Dentist: _____

Date: _____

Telephone # _____

Witness: _____

Medical Problems

Date: _____

Comments _____

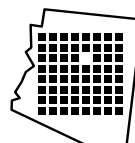
Medications: _____

Allergies: _____

Hospital preference: _____
(if stable)

Date of last tetanus booster: _____

This form has been developed and approved by the Arizona Chapter of the American College of Emergency Physicians. Requests for additional copies and comments may be forwarded to the address at the right.



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