You have probably made plans for someone to care for your child or children when not in your care. This could be care from a grandparent, daycare provider, aunt or uncle, or someone from your own neighborhood. To help with these plans, we are providing a consent form and medical data questionnaire 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 both the consent form and medical 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.

This will be a load off their minds, and yours. Complete the form today.

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

Consent for medical treatment of a minor child ...

I, (We) _____ and _____
(name)   (name)

of _____, _____, _____, do
(city)   (county)   (state)

hereby state that I (we are) the parent(s) or legal guardian(s) of

_____, a minor, age _____, born _____,
(name)   (age)   (date)

who resides with me (us) at _____.
(street address)

I (We) authorize _____, an adult, who resides
(name)

at _____ in the city of
(address)

_____, county of _____, state of
(city)   (county)

_____ to consent to any necessary examination, anesthetic, medical
(state)

diagnosis, surgery or treatment, and/or hospital care to be rendered to the above-named

minor under the general or special supervision and on the advise of any physician or

surgeon licensed to practice medicine in the state(s) of

_____.
(name of states)

Dated this _____ day of _____, 20 _____.

_____   _____
(signature of parent or guardian)   (signature of witness)

FAMILY DOCTOR:

_____

Phone: _____

MEDICAL INSURANCE CARRIER:

_____

ID # _____

Member's Name:

_____

Benefit code: _____
Account # _____

MEDICAL HISTORY:

Allergies, if any, and medication:

_____
_____
_____

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

_____
_____
_____

Medicine your child is taking now:

_____
_____
_____

EMERGENCY NOTIFICATION:

In the event of serious injury or illness, the parent or parents of the minor child may be reached as follows:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

This form is also available online at:

www.kdhmadison.org

use the Patients link
or call Community Relations
(812) 265-0619 or 265-0128

Medical Consent Form

KDH
King's Daughters' Health