Patient Label

Hutchinson Regional Medical Center

Consent for Treatment of a Minor

CO0001

In the event my child needs medical treatment and Hutchinson Regional Medical Center cannot reach me, I authorize the following adult(s) to give consent for medical treatment, including emergency surgery.

Authorized Adult(s):

Name:

_____

Name:

_____

My Child's Information:

Name:

_____

Home Address:

_____

Date of Birth:

_____

Chronic Illnesses or Allergies:

_____

Current Medications:

_____

Date of Last Tetanus Shot:

_____

Family Physician: _____ Phone: _____

Health Insurance Company: Health Insurance Group #: _____

Person Responsible for Payment: _____ Phone: _____

Employer of Person Responsible for Payment: _____

My Information:

I am the child's:

❒ Parent ❒ Stepparent ❒ Legal Guardian ❒ Other: _____

Home Address: _____ Phone: _____

Period of Authorization:

I authorize this consent to be in effect from (date) _____ to (date) _____

I understand the person(s) I authorized must be at least 18 years old and must be prepared to present identification if my child needs medical treatment. I also understand the authorized person(s) must present this form to Hutchinson Regional Medical Center.

My Signature: _____ Date: _____

Signature of Witness: _____ Date: _____

In case of emergency the following person will know how to reach me:

Name:

_____

Home Address:

_____ Phone: _____