Medical History

Allergies (medication, food, other)

_____

_____

_____

_____

_____

Chronic/existing disease/medical problems

_____

_____

_____

Date of last tetanus shot

_____

In An Emergency, Parent(s) Guardian(s)
Can Be Reached As Follows

_____

_____

_____

482016

Before You Leave

Consent for Medical
Treatment of a Minor Child

When You Must Leave Your Child
When you have to leave your child or children, you are concerned for all aspects of their care.

You want to arrange for their wants and needs, but even more, you want to make sure they are safe. We at Henry County Hospital want to provide you with this special consent for medical treatment form. Should your child become ill or be injured, this form will give valuable medical data and consent for treatment in your absence.

When Your Child Must Leave You
As your child/children grow there are many opportunities for them to travel without you. If your child is leaving you for a trip to camp or a school trip, or if they are traveling with someone other than yourself, this information will be helpful to ensure the prompt medical care he or she might need.

Planning Ahead
After all the information and consent areas are filled in, give this folder to whomever will be taking care of your child in your absence. They can present it to the physician or hospital in the event your child needs care.

Planning ahead can give you peace of mind when you and your child/children are separated. We hope all your travels will be pleasant ones.

Please note: You must have this document notarized.

Consent For Medical Treatment Of A Minor Child

I, (We) _____ and _____
Name Name

of _____
City County State

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

_____
Name

A minor, age _____, born _____, who resides with me (us) at
Birthdate

_____
Street Address

I (We) authorize _____, an adult who resides at
Name

_____
Street Address City County State

To consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to the above-named minor under the general care of special supervision and on the advice of any physician or surgeon licensed to practice medicine in the state(s) of _____.

Dated this _____day of _____, 20_____.

_____
Signature(s) of parent(s) or guardian(s)

_____ _____
Notary Public / Date My Commission Expires