

FAIRFIELD MEDICAL CENTER
Lancaster, Ohio

CONSENT FOR TREATMENT OF A MINOR CHILD

NAME OF CHILDREN 1. _____ AGE _____

2. _____ AGE _____

3. _____ AGE _____

FAMILY PHYSICIAN _____

NAME OF RESPONSIBLE PARTY IN ABSENCE OF PARENTS OR LEGAL GUARDIAN

ADDRESS _____

TELEPHONE _____

NAME OF LEGAL GUARDIAN _____

ADDRESS _____

TELEPHONE _____

DATE OF LAST TETANUS SHOT 1. _____ 2. _____ 3. _____

LIST OF ALLERGIES OR SPECIAL HEALTH PROBLEM CHILD OR CHILDREN MAY HAVE.

I hereby give my consent to Fairfield Medical Center and physicians employed at Fairfield Medical Center to provide EMERGENCY treatment as necessary.

Please check one or both of the following:

_____ Attempt to contact me prior to treatment. Telephone _____

_____ Attempt to contact me after treatment. Telephone _____

Please sign and have your caregiver keep it with them to be presented to registration if services are needed during your absence.

Signature of Parent or Legal Guardian _____ Date _____

Witness _____

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