

If You're Going Away...



You have probably made provisions for someone to care for any of your children not going with you. To help you with these arrangements, we are providing this consent form and medical data questionnaire which will be valuable should your child be ill or injured while you are away.

The same thing is true if your child is leaving you at home — going away to camp or traveling with someone other than yourself. This information will be helpful — maybe even required — to give your child the prompt medical care he or she may need.

Enter all the information requested, have signature(s) notarized, and give this folder to the persons who will be responsible for your children. If care is needed, they can take it with them to the hospital or doctor — with permission granted and health information written down.

It will be a load off their minds — and yours.

Date completed: _____

FAMILY DOCTOR:

Phone: _____

MEDICAL INSURANCE CARRIER:

Identification number:

Member's Name:

Benefit Code: _____

Account Number: _____

MEDICAL HISTORY:

Allergies, if any, including medication:

Chronic or existing diseases or medical problems (eg: diabetes, epilepsy):

Medicines your child is taking now:

Date of last tetanus booster:

In an emergency, parents can be reached as follows:

As a member of Ascension Health and St. Vincent Health, we are called to:

Service of the Poor

Generosity of spirit, especially for persons most in need

Reverence

Respect and compassion for the dignity and diversity of life

Integrity

Inspiring trust through personal leadership

Wisdom

Integrating excellence and stewardship

Creativity

Courageous innovation

Dedication

Affirming the hope and joy of our ministry

Presented as a public service by



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Consent for medical treatment of a minor child

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

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

that I am (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,
(name)

who resides at _____ in
(address)

the city of _____, county of _____,
(city) (county)

state of _____ to consent to any necessary examination,
(state)

anesthetic, medical 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 advice of any physician or surgeon licensed to practice medicine in the state(s) of _____.

This medical consent is effective on the following date: _____ up to and including: _____ the period of time during which I/we will not be reasonably available to make such decisions for my/our child.

I/we DO DO NOT (circle one) authorize the person to whom we have delegated consent to give this healthcare decision-making authority to another.

Dated this _____ day of _____, 20 _____.

Signature of parent or guardian

Signature of parent or guardian

I declare that I am an adult at least eighteen (18) years of age and that at the request of the above-named parent making this delegation, I witnessed the signing of this document by the parent on the date noted above.

Signature of witness

Printed name

Address and phone number