



**Lutheran
Health Network**
Lutheran Children's Hospital

LutheranChildrensHospital.com

PARENTAL CONSENT FORM

▶ Consent for medical treatment

DID YOU KNOW THAT, IN YOUR ABSENCE, NO ONE CARING FOR YOUR CHILDREN CAN AUTHORIZE MEDICAL CARE WITHOUT YOUR WRITTEN PERMISSION? If you leave your child with a sitter while you are working or traveling, complete this form, have it witnessed and leave it with your caregiver. This will ensure that, in an emergency, your child will receive prompt, necessary medical care even if you are not there. The caregiver should have this form available if a child requires medical treatment without the parent/guardian present.

CALL 911 IN AN EMERGENCY.

Make copies of blank form for future use.
Can be used at any healthcare facility.

I (We), _____ and _____
(parent/guardian name) (parent/guardian name)
of _____, _____, _____ do hereby state
(city) (county) (state)
that I am (we are) the parent(s) or legal guardian(s) of _____,
(name of child)
a minor, age _____, born on _____,
who resides with me (us) at _____
(street address)

(city, state, zip)

I (we) authorize _____, an adult
(name of caregiver)
over 18 years of age, who resides at _____ in the city of
(address of caregiver)
_____, state of _____, to consent to any
necessary examination, anesthesia, surgery, 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 _____

for the period _____ to _____
(specific date) (specific date)

Today's date: _____

SIGNATURE(S) OF PARENT(S) OR GUARDIAN(S):

▶ _____ ▶ _____

Witness: _____ Witness: _____

PARENT(S)/GUARDIAN(S) CONTACT NUMBERS:

Cell: _____ Other: _____
Cell: _____ Other: _____

Child's physician: _____
Phone: _____

Allergies (including medications):

MEDICAL INSURANCE

Insurance name: _____
Insurance phone: _____
Policyholder's name: _____
Identification number: _____
Group/policy number: _____

Chronic/existing diseases or medical problems:

Medications: _____
Date of last tetanus injection or booster: _____