_____

Family Physician

_____

Telephone

_____

Family Dentist

_____

Telephone

Primary Insurer

_____

Name of Insurance Company

_____

Identification Number

_____

Group Number (If Any)

_____

Signature (Insured Parent or Guardian)

Additional Insurance

_____

Name of Insurance Company

_____

Identification Number

_____

Group Number (If Any)
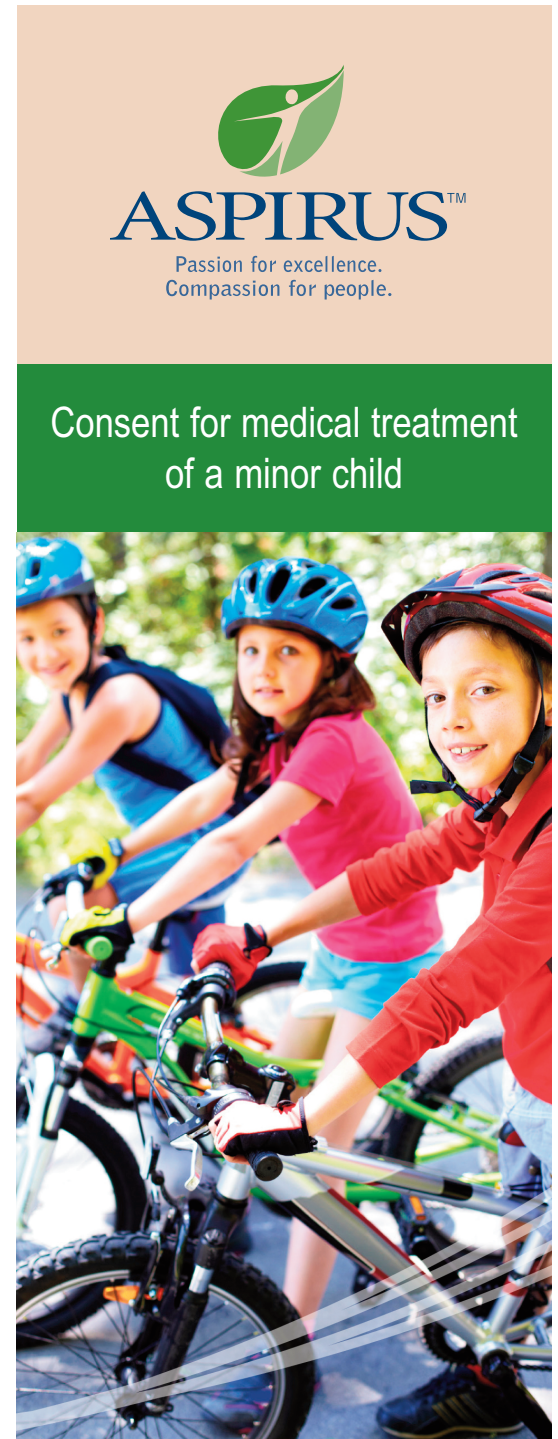
_____

Signature (Insured Parent or Guardian)

In addition to providing the information above, please attach a photocopy of all insurance cards.

Parent or guardian can be located at the following address(es) and phone number(s):

_____

_____

_____

_____

_____

_____

*This is a legal document.
Take it with you and give it to the
physician, dentist or hospital representative
so that necessary treatment can be given
to a child whose parents or guardians
cannot be contacted for permission.*

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RIVERVIEW HOSPITAL & CLINICS
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Consent for medical treatment of a minor child

Please complete a separate form for each minor child.

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

_____ , _____ , do hereby state that I am (we are) the parent(s) or legal guardian(s) of :
(county)   (state)

_____ , minor, age _____ , born _____ , who resides with
(name)   (age)   (birthdate)

me (us) at _____ .
(address)

I (We) authorize _____ , an adult, who resides at _____ in the city of

_____ , county of _____ , state of _____ to act in my (our)

behalf in authorizing medical, dental, surgical care and hospitalization for the above named minor for the period of time (not to exceed one year) beginning:

_____ _____ _____ and ending _____ _____ _____ .
(month)   (day)   (year)   (month)   (day)   (year)

I (We) do hereby indemnify and hold harmless the physicians, dentists, hospital and other persons who act in reliance upon this authorization.

_____   _____
(signature of parent or guardian)   (signature of parent or guardian)

_____   _____
(signature of witness - anyone over age 18)   (date signed)

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as medical, dental, surgical care or hospitalization may be required.

Allergies: _____   Date of Last Tetanus Booster: _____

Chronic Diseases or Medical Problems/Needs: _____

_____

Current Medications: _____

_____

(Over)