



Consent

Consent for Medical/Surgical Care/Emergency Treatment

****PLACE A CHECK MARK NEXT TO THE APPROPRIATE CONSENT BELOW****

Consent for Fort HealthCare to Provide Treatment

I, _____, as the parent or guardian of _____ (DOB _____) hereby voluntarily consent to the rendering of medical care, including diagnostic procedures, surgical and medical treatment and blood transfusions, by Fort HealthCare staff or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment of my child's condition.

I have read this form and certify that I understand its contents.

Consent for Other Adults to Authorize Treatment

I hereby authorize _____ (Name of Person(s) Authorized to Consent to Care in Absence of Parent/Guardian) who will be caring for my minor child _____

(DOB _____) for the period _____ to _____ (not to exceed one year from date of signature)

to arrange for routine or emergency medical care and treatment necessary to preserve the health of my child.

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

Name: _____ Address: _____ (Mother, Father or Legal Guardian)

Signature: _____ Date: _____ (Mother, Father or Legal Guardian)

Contact information to be completed for both consents

In case of emergency I can be reached at (please list contact information for all parents or guardians):

Family Physician/Pediatrician: _____

Any other health care provider(s) involved in child's care: _____

Original Date: 10/6/2015	Patient Sticker
Revision Date: 9/29/17	
Approved: HIM/UR 12/14/15, 10/31/17	