MEDICAL CONSENT

In the case of emergency I give

permission to seek and authorize treatment for my minor child

I authorize emergency medical personnel to perform all necessary procedures for the well-being of my child.

Child's Full Name:			
Date Of Birth:		SSN:	

MEDICAL INFORMATION	
Physician Name:	
Practice Name:	
Phone:	
Hematologist Name:	
Hemophilia Treatment Center Name or Private Hematologist's Hospital Affiliation:	
Phone:	

HEALTH INSURANCE INFORMATION	
Provider (Insurance Company Name):	
Address:	
Group #:	Member ID #:
Name of Primary Insured:	
Insurance Company Phone Number	

CRITICAL INFORMATION	
Blood Type	
Type of Bleeding Disorder	
Severity	
Name of clotting factor (brand name)	
Current weight	
Current standard dose of factor	
How often patient normally receives factor	
How factor is normally infused (port, central line, peripheral infusion, etc.)	
Allergies	
Other	

PREFERRED HOSPITAL

Signed:

_____ _____

Parent/Legal Guardian of above named minor Date