Avita Health System is providing this consent form and medical data questionnaire to help avoid possible delays in obtaining treatment for an ill or injured child.

It is a consent for care of your minor child, who may become ill or injured when you or a legal guardian are not present.

In such a case, a frustrating situation could develop for both the child, patient and those responsible for care or treatment.

Think of these examples:

- A child is injured while in the care of a babysitter or stepparent and requires medical aid.
 - Neither can be accepted as a legal substitute for the parent or guardian.
- A young adult under age 18, traveling alone, becomes ill and is taken to a hospital for treatment.

This minor legally cannot give consent.

To be absolutely safe, you should provide written authorization for a responsible adult to approve medical treatment for your child(ren) in the event you cannot be reached.

If care or treatment is needed, they should take this form with them to the hospital or doctor.

Please leave specific information as to where you can be contacted at all times, if you do not wish to leave a signed consent.

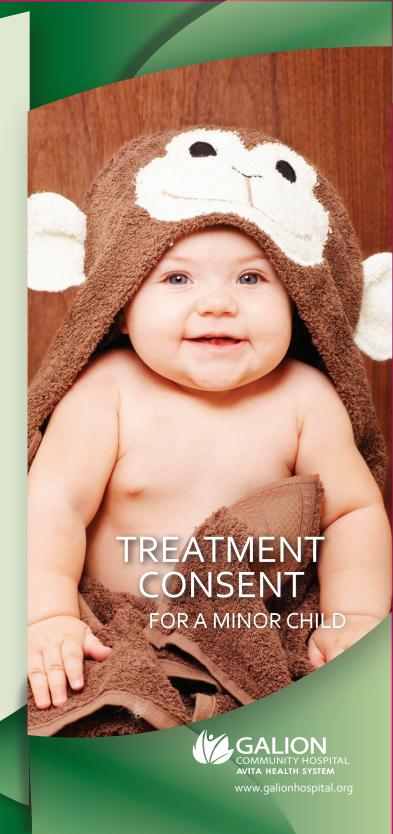
IN AN EMERGENCY:

Parents or legal guardian(s) can be reached as follows or by contacting the person(s) listed below:

NAME:	PHONE:			



269 Portland Way South Galion, Ohio 44833 419-468-4841 www.qalionhospital.org





	I (We)				
FAMILY DOCTOR:					
	of				, do hereby state that I am
PHONE:	(we are) the parent(s) or legal guardian(s) of,				
	a minar aga	harn			
MEDICAL HISTORY:	a minor, age	, born		DATE	who resides with
	me (us) at				
Allergies, if any, including medications:	me (us) at STREET ADDRESS				
	I (We) authorize		NAME OF RESPONS		, an adult,
				IBLE PERSON	
	who resides at				
Tetanus (date of last booster):					CITY
	COUNTY		, to consent to a	ny necessary exan	nination, anesthetic, medical
Chronic or existing diseases or medical problems	diagnosis, surgery or treatment, and/or hospital care to be rendered to the above named minor under the				
(asthma, diabetes, epilepsy, etc.):	general or special su	upervision and on th	ne advice of any phys	sician or surgeon lic	ensed to practice medicine in
	+l C+-+-(-) -f				
	the State(s) of				
	Dated this	day.of		20	
Medications your child is taking:		day of		, 20	·
iviedications your criticals taking.					
	SIGN	NATURE OF PARENT OR GUAR	RDIAN	SIGNATURE OF PAREN	IT OR GUARDIAN
	Witness:			Date:	
MEDICAL INSURANCE CARRIER(s):					
MEDICAL INSURANCE CARRIER(3).	Witness:			Date:	
					
Identification number:					
NA					
Member's name:					

Group number: