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:

1. 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.
2. 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:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

GALION
COMMUNITY HOSPITAL
AVITA HEALTH SYSTEM

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

TREATMENT CONSENT

FOR A MINOR CHILD

GALION
COMMUNITY HOSPITAL
AVITA HEALTH SYSTEM

www.galionhospital.org

FAMILY DOCTOR:

_____

PHONE:

_____

MEDICAL HISTORY:

Allergies, if any, including medications:

_____

_____

_____

Tetanus (date of last booster):

_____

Chronic or existing diseases or medical problems (asthma, diabetes, epilepsy, etc.):

_____

_____

_____

Medications your child is taking:

_____

_____

MEDICAL INSURANCE CARRIER(s):

_____

_____

Identification number:

_____

Member's name:

_____

Group number:

_____

I (We) _____
NAME(S) OF PARENT(S) OR GUARDIAN(S)

of _____ (CITY), _____ (COUNTY), _____ (STATE), do hereby state that I am (we are) the parent(s) or legal guardian(s) of _____ (NAME OF CHILD),

a minor, age _____, born _____ (DATE) who resides with me (us) at _____ (STREET ADDRESS).

I (We) authorize _____ (NAME OF RESPONSIBLE PERSON), an adult, who resides at _____ (STREET ADDRESS), _____ (CITY), _____ (COUNTY), _____ (STATE), to consent to any necessary examination, anesthetic, medical diagnosis, surgery or 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 _____

Dated this _____ day of _____, 20 _____.

_____ (SIGNATURE OF PARENT OR GUARDIAN) _____ (SIGNATURE OF PARENT OR GUARDIAN)

Witness: _____ Date: _____

Witness: _____ Date: _____