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: Phone:

Hemophilia Treatment Center Name or Private Hematologist's Hospital Affiliation:

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

Hospital:

Signed: Date:

Parent/Legal Guardian of above named minor.