**MID-KENTUCKY PRESBYTERY**
**CONSENT FOR MEDICAL TREATMENT OF A MINOR**

Child's Name:_____Age:_____DOB:_____

Medication child is taking:_____

Allergies (including food, drugs, etc.):_____

Special Medical Problems (include heart, lung, diabetes history):_____

_____

Date of last Tetanus:_____Are immunizations up to date?_____

Name of Parent/Guardian _____ Address: _____

Home Phone: _____ Work Phone: _____

Name of Spouse: _____ Address: _____

Home Phone: _____ Work Phone: _____

Pediatrician: _____ Office Phone: _____

If parent or guadian cannot be reached, contact:

Name: _____ Phone: _____

Name: _____ Phone: _____

Insurance Company: _____

Policy #: _____ Policy Holder: _____

## Medical Treatment Authorization

In case of a medical need involving the minor named above, I request the hospital staff to contact me (or my spouse or representative) at the numbers provided. In the event that none of the persons listed can be reached, I grant written permission to the hospital's emergency medical staff to render medical care as deemed appropriate. I (We) agree to pay for the normal and customary charges of the hospital for any treatment or medication received by said minor. I also agree to notify the hospital in writing if I cease to be the guardian or if there are any changes in the above authorization.

_____ _____ _____
Signature Witness (if possible) Date