

Family Doctor: \_\_\_\_\_

Phone: \_\_\_\_\_

**Medical Insurance:**

Insurance Carrier: \_\_\_\_\_

Identification Number: \_\_\_\_\_

Member's Name: \_\_\_\_\_

Benefit Code: \_\_\_\_\_

Account Number: \_\_\_\_\_

**Medical History:**

Allergies (including medications): \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medicines your child is taking now:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

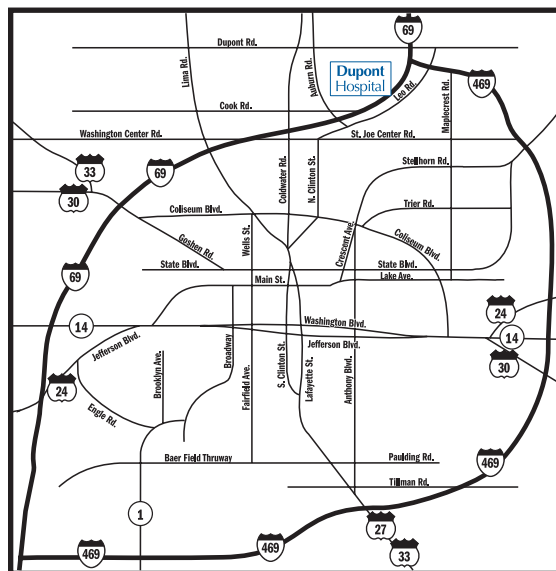
Date child received last Tetanus injection or booster: \_\_\_\_\_, \_\_\_\_\_

**In an emergency, parent(s) or guardian(s) may be reached at:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_



**Dupont  
Hospital**

2520 E. Dupont Rd.  
Fort Wayne, IN 46825  
(260) 416-3000

[www.theduponthospital.com](http://www.theduponthospital.com)

*Get well soon™.*

Lutheran Health Network Member

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**When you  
must leave  
your children,**



Affiliated with



**leave them  
protected.**

**Dupont Hospital**

## Parental Consent Form

Protecting your children while you travel means more than getting a sitter. To be absolutely safe, you should provide written authorization for a responsible adult to approve any necessary emergency medical treatment for your children.

Unless a child's injuries are life-threatening, hospital personnel and physicians cannot treat him or her without parental or guardian consent. As a result, your child may suffer unnecessary discomfort while waiting for you to be reached to approve stitching a cut or setting a broken arm.

Each time you go out of town, complete the form on the right and provide the information requested on the back. A separate, dated consent form is necessary for each of your children each time you leave town.

Please ask the adult you've designated on the consent form to keep this brochure handy. It should be taken to a hospital or a doctor's office if a child requires medical treatment.

Blank forms may be duplicated for personal use.



## Consent for Medical Treatment of a Minor

I (We), \_\_\_\_\_ and \_\_\_\_\_  
(name) (name)

of \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(city) (county) (state)

do hereby state that I am (we are) the parent(s) or legal guardian(s) of:

\_\_\_\_\_, a minor, age \_\_\_\_\_, born on \_\_\_\_\_,  
(name) (age) (date)

who resides with me (us) at \_\_\_\_\_  
(street address)

\_\_\_\_\_  
(city, state)

I (we) authorize \_\_\_\_\_, an adult over 18 years of age, who  
(name)

resides at \_\_\_\_\_ in the city of \_\_\_\_\_, state of  
(street address) (city)

\_\_\_\_\_ to consent to any necessary examination, anesthetic, medical  
(state)

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 \_\_\_\_\_  
(states)

\_\_\_\_\_ for the period from \_\_\_\_\_, \_\_\_\_\_ to \_\_\_\_\_, \_\_\_\_\_  
(states) (date) (year) (date) (year)

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
(day) (month) (year)

Signature(s) of parent(s) or guardian(s):

\_\_\_\_\_

Witness: \_\_\_\_\_ Witness: \_\_\_\_\_

*Please complete the form on the back.*