EMERGENCY CONSENT FOR MINOR PATIENT CARE & TREATMENT

Injuries to children can often occur at times when a parent or guardian cannot be immediately reached. Advance written consent for treatment of minors can save time, pain, anxiety and unnecessary delay. **Fill out one form for each child**. Have this form available with your child if they require evaluating, care and possible treatment at Evergreen Hospital and you are unavailable. This consent and information form will not replace our staff from trying to reach a parent or guardian, and should be of value to any health care facility.

Patient Information: *(Please use phone number with area code, and apartment number where applicable.)*

Was your child born or ever registered as a patient at Evergreen? YES _____ NO _____

Child's Legal Name: Last: _____ First: _____ Middle: _____

Parent/Legal Guardian: Name(s): _____

Name(s): _____

Child's Address: Street: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____ - _____

Phone Numbers: Home: (_____) _____ - _____ Cell: (_____) _____ - _____

Date of Birth MM/DD/YYYY ____/____/_____ Age: _____ Sex: _____ Religion: _____

Medical Information:

Significant medical history/problems? _____

Medication allergies if any: _____

Medications taken on a daily basis: _____

Last date of Immunizations?: _____ Date of last tetanus/DPT/DT?: _____

Date of last hepatitis?: _____ Other pertinent info.?: _____

Primary Care Physician:

Physician Name: _____ Phone: (_____) _____ - _____

Specialty if known: _____

Guarantor Information: *(Person who carries the primary insurance –OR– responsible for the payment of charges incurred.)*

Name: Last: _____ First: _____ Middle: _____

Address: Street: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____ - _____

Phone #: (_____) _____ - _____ D.O.B.: MM/DD/YYYY ____/____/_____ Sex: _____ Relation to child: _____

Employer Name: _____

Address: Street: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____ - _____

Phone #: (_____) _____ - _____ Occupation: _____ Status: _____

Insurance Information: (Primary Plan)

Name of Insurance Plan: _____

Address: Street: _____ Suite #: _____

City: _____ State: _____ Zip Code: _____ - _____

Policy Holder's Name: Last: _____ First: _____ Middle: _____

D.O.B.: MM/DD/YYYY ____/____/_____ Relationship to the patient: _____

Policy #: _____ Group #: _____

Release:

*The undersigned hereby authorizes **Evergreen Hospital Medical Center** to render emergency care to (child's name) _____ Including such x-ray examinations, laboratory procedures, anesthesia, medical or surgical treatment or other hospital services ordered by the attending physician, his/her assistants or designees, I also authorize the release of all information necessary to settle any insurance claims. I understand I am responsible for charges not covered by insurance.*

Signature of parent or guardian _____ *Date:* _____