



200801371

MEDICAL INFORMATION

Authorization to seek medical care for your minor child in your absence.

CHILD'S NAME

print name here



FLORIDA HOSPITAL
Flagler

The skill to heal. The spirit to care.

60 Memorial Medical Parkway | Palm Coast, FL 32164 | (386) 586-2000

www.FloridaHospitalFlagler.com

CONSENT FORM

If your child needs medical care, the law requires that you, the parent or legal guardian, give your permission. To avoid possible delay in the treatment of an ill or injured child, Florida Hospital Flagler is providing this consent form and medical history questionnaire for you to leave with the person or persons who are caring for your child during your absence.

This signed consent form authorizes the babysitter, relative, or other persons you have named to seek immediate medical attention for your child when it is needed, without delay. Even stepparents and grandparents must have your authorization to seek medical care for your minor child in your absence.

In addition, the medical information requested in this form can provide some important answers for the physicians who may be called upon to treat your child. We suggest you complete one of these forms for each of your children when you plan to leave them in someone else's care. It is in your best interest that your child's healthcare needs will be met when it matters.

CHILD'S MEDICAL HISTORY

Child Name: _____

Allergies, *if any*, including medication: _____

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

Medications child is now taking: _____

INSURANCE INFORMATION

Medical insurance carrier: _____

Group: _____

Policy or Contract Number: _____

Insured's Name: _____

Social Security Number: _____

CONSENT FOR MEDICAL TREATMENT

I (We) _____ the parent(s) or legal guardian(s) of _____, a minor, (birthdate: _____), hereby grant my/our permission for _____, who is caring for my child during my/our absence, to seek medical care for the above-named minor when he/she finds it to be necessary.

The medical care shall cover illness, accident or injury. In the event of Emergency Department care, when consultation or follow-up care is required, it is my/our preference that

Dr. _____ our family physician, be contacted at _____ (phone number).

I (We) understand that no treatment can be given without the above or similar statement of permission. This consent is valid for _____ (period not to exceed one year).

Dated this _____ (day) of _____ (month), 20____.

PARENT/LEGAL GUARDIAN SIGNATURE
(SIGNED IN PRESENCE OF NOTARY)

PARENT/LEGAL GUARDIAN SIGNATURE
(SIGNED IN PRESENCE OF NOTARY)

State of Florida, County of _____ on this _____ (day) of _____ (month), 20____, personally appeared before me the above named person, who is personally known to me or who has produced _____ as identification and who did take an oath.

Notary Public Seal

NOTARY PUBLIC SIGNATURE