Medical Information

Please print and be thorough.

Chronic or Existing Medical Conditions (e.g., asthma, seizures, diabetes)

_____

_____

_____

_____

Known Allergies

- ❑ Anesthetics
- ❑ Antibiotics (Please List)

_____

_____

- ❑ Aspirin
- ❑ Codeine
- ❑ Demerol
- ❑ Insect Stings
- ❑ I.V.P. Dyes
- ❑ Morphine
- ❑ Novocaine
- ❑ Penicillin
- ❑ Shellfish
- ❑ Tetanus Toxoid

❑ Other (Please List) _____

_____

_____

_____

Current Daily Medications

_____

_____

_____

_____

_____

Recent Shots and Vaccines

Tetanus/Date _____

Other/Date _____

_____

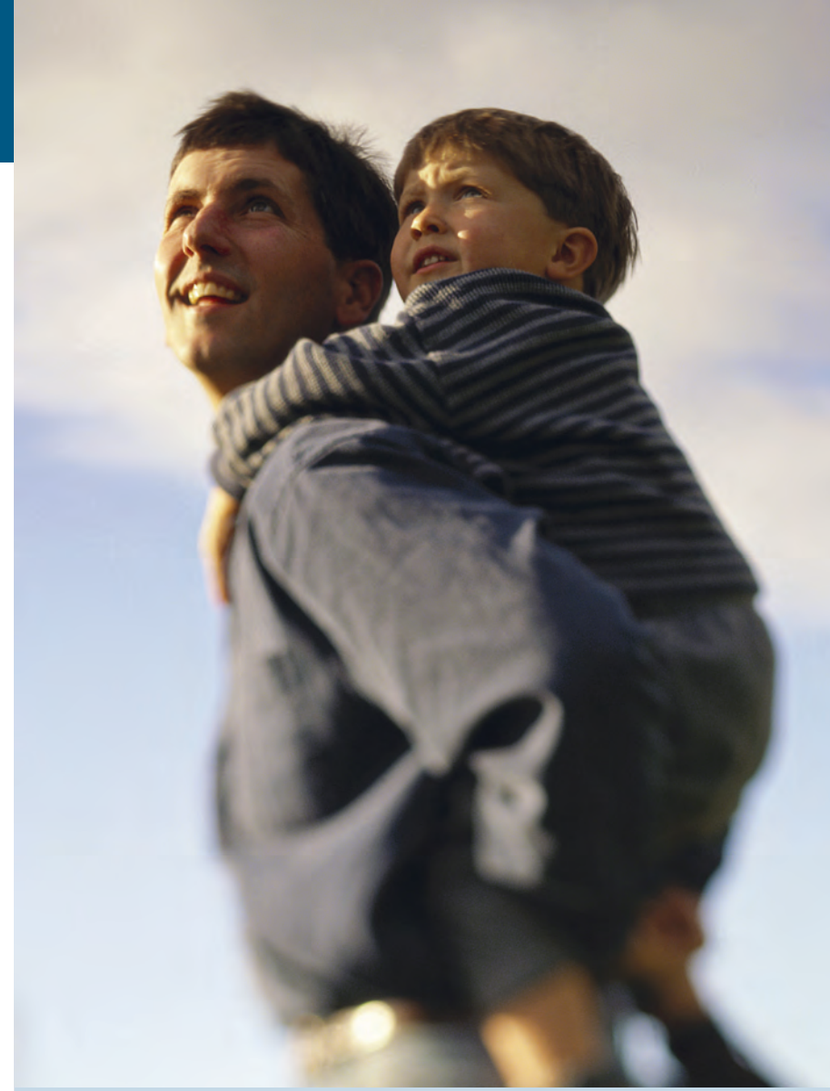
_____

_____

St.Vincent

317-338-CARE (2273)

stvincent.org



Parental Consent For Medical Treatment

St.Vincent

THE SPIRIT OF CARING®

When you go away, make sure your children are protected.

Accidents or sudden illness involving your children can occur at any time, any place. Unfortunately, parents or guardians are not always immediately available to give proper consent and valuable medical information.

St.Vincent would like to help you prevent this from happening. This Parental Consent for Medical Treatment form not only gives a caregiver permission to treat your child, it also provides valuable facts and any other special information about your child's medical history.

Please be thorough and complete all the information. You must complete a separate form for each child. Then, provide copies of the form to every person who is responsible for caring for your child. Remember to send along a form any time your child goes away, whether it's to camp or just to a friend's house for the weekend.

Complete this form today and you can feel comfortable knowing your child will receive prompt, personalized medical attention, no matter where you may be. If you need additional consent forms, or have any questions, please call the St.Vincent CARE Line at 338-CARE, or stop by the Emergency Department at any St.Vincent hospital location.

St.Vincent Hospitals and Health Services Consent for Medical Treatment

Child's Name _____ Date of Birth _____

Home Address _____ Home Phone # _____

City/State/Zip _____

Caregiver's Name _____ Phone # _____
(The adult given Supervisory Responsibility over a child by a parent or guardian)

Parental Contact _____ Phone # _____

The above named caregiver shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures (including administration of anesthesia, blood transfusions, diagnostic tests, etc.), for the above named child, which may be required during my absence. If circumstances permit, I would like to have our doctor consulted in connection with such treatment.

Please attempt to contact me at the following number: _____

This consent serves as permission for treatment by St.Vincent, its associates and physicians. (Note: Consents are not required in emergency situations.) The consent also shall include all procedures for which consent or authorization is required under the policies of St.Vincent Hospitals and Health Services. I agree to pay for all services provided to my child in my absence. This authorization shall be effective until:

- ❑ a) _____
- ❑ b) unless earlier revoked by me.

Signatures

_____
Parent, Guardian *(Circle One)* Date

_____
Parent, Guardian *(Circle One)* Date

_____
Witness Date

(Please Complete Reverse Side)

Family Physician

Name _____

Address _____

Phone # _____

Insurance Information

Company Name _____

Policy Number _____