



Hendricks Regional Health Consent for Treatment

Protect your children while you're away.

When your child is with another caregiver, you know they are in good hands – but what if a medical situation arises? It is important to make sure to give all caregivers permission to seek medical assistance for your children.

By completing this form you are granting permission for Hendricks Regional Health to provide medical assistance if it becomes necessary when your child is being cared for by someone else.

Please provide all requested information. You must complete a separate form for each child. Then, give copies of the form to every person who is responsible for caring for your child.

If your child is under the care of a minor (under 18 years old), the minor's parents must have authorization to give consent for medical treatment.

Please Note: Physicians have discretion regarding certain medical procedures, and may require direct parental consent before performing them.

Dependent Name _____ Dependent Date of Birth _____

TO WHOM IT MAY CONCERN (please print clearly)

I (we) _____ and _____
name name

of _____, _____, _____
city county state

grant permission for Dr. _____ and/or Hendricks Regional Health emergency department

and/or Immediate Care Centers to provide medical care as deemed necessary to the above named dependent

while being cared for by _____, effective from _____ through _____

_____. If the person caring for my child is a minor (under age 18), I grant permission for

the minor's parent/guardian, _____, to request and authorize in writing, or

as otherwise requested by Hendricks Regional Health, any and all examinations, medical treatment and/or

procedures to or for the above named minor, either on or off the premises of Hendricks Regional Health,

as may be deemed advisable or appropriate by any physician or surgeon licensed to practice medicine

in the State of Indiana.

SIGNATURES (must be completed)

parent/guardian and date

address and zip code

parent/guardian and date

witness and date

FAMILY PHYSICIAN

Name _____

INSURANCE COMPANY

Co. name _____

Address _____

I.D. (policy) number _____

Phone number _____

(PLEASE COMPLETE REVERSE SIDE)

Medical Information

Chronic or Existing Medical Conditions (i.e. asthma, epilepsy, diabetes)

Recent Shots and Vaccines

Tetanus/DPT & Date _____

Other & Date _____

Current Daily Medications

Known Allergies

- Anesthetics
- Antibiotics

- Aspirin
- Codeine
- Cortisone
- Demerol
- Insect Stings
- I.V.P. Dyes
- Morphine
- Xylocaine/Novacaine
- Tetanus Toxoid
- Other _____

Blood type

- O
- A
- B
- AB

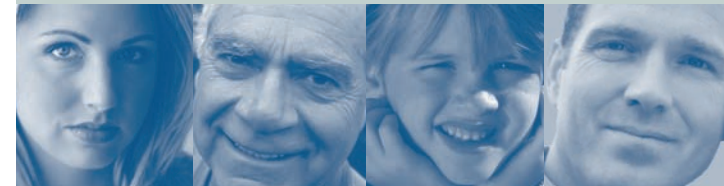
- Positive
- Negative

HRH Emergency Department
1000 East Main Street, Danville
(317) 745-3450

HRH Immediate Care Avon
8244 East U.S. 36
(317) 272-7500

HRH Immediate Care Plainfield
1100 Southfield Drive
(317) 839-7200

Parental Consent and Medical Release Form



 **Hendricks
Regional Health**

Advanced medicine all around you.