

# Parental Consent for Medical Treatment of a Minor Child

To avoid possible delay in providing medical treatment in the event your child becomes ill or injured in your absence, Ohio Valley Medical Quick Care Inc. offers this form for medical consent and history. It offers assurance that your minor child will receive prompt, personalized attention if you or a guardian are not immediately available.

Please fill out the following form and provide copies to each person who is responsible for caring for your child. If care or treatment is needed, they can present this information to a physician or healthcare provider. Please note:

- You must complete a separate form for each child and caregiver.
- Please update the information at least every six months.
- If all blanks are not filled out completely, the form may not be considered valid.

Child's name \_\_\_\_\_ Child's birth date \_\_\_\_\_

Home address \_\_\_\_\_  
(street) (city, state, ZIP)

Parent's/Guardian's name \_\_\_\_\_ day ph. \_\_\_\_\_ evening ph. \_\_\_\_\_

Parent's/Guardian's name \_\_\_\_\_ day ph. \_\_\_\_\_ evening ph. \_\_\_\_\_

Home address \_\_\_\_\_  
(street) (city, state, ZIP)

Alternate phone number (if not at work or home) \_\_\_\_\_

I (we) the parent(s) or guardian(s) named above, authorize the following adult caregiver to consent to any necessary examination, anesthetic, blood transfusion, medical diagnosis, etc. and/or hospital care to be rendered to the above-named minor child under the general or special supervision and on the advice of any licensed physician. I (we) agree to pay for all services provided to my child in my absence.

Caregiver \_\_\_\_\_ Phone \_\_\_\_\_

## Signatures

Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

## Insurance Information

Insurance company \_\_\_\_\_ Member name \_\_\_\_\_

Insurance policy number \_\_\_\_\_

## Physician Information

Child's physician \_\_\_\_\_ Phone \_\_\_\_\_

Parent's physician \_\_\_\_\_ Phone \_\_\_\_\_

**Medical History**

Allergies, including allergies to medicines, anesthetic, foods, etc.

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Chronic or existing diseases or medical problems (diabetes, epilepsy, etc.)

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Medications child is taking (please include dose information)

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**Vaccines**

Date of last tetanus \_\_\_\_\_

Other \_\_\_\_\_