CAPITAL INTERNAL MEDICINE ASSOCIATES, P.C.

Parental Consent for Medical Treatment

Child's Information

_____ _____
Child's Name Date of Birth

_____ _____
Home Address Home Phone Number

_____
City, State, Zip Code

_____ _____
Parental Contact Phone Number

Caregiver Information

_____ _____
Caregiver's Name Phone Number

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 consult in connection with such treatment.

Please attempt to contact me at the following telephone number:

_____

This consent serves as permission for treatment by _____ (Clinic Name). Note: Consents are not required in emergency situations. I agree to pay for all services provided to my child in my absence. This authorization shall be effective until: (select one)

a) _____ (Month, Day Year) b) unless earlier revoked by me.

Signatures

_____
Parent/Guardian (circle one) Date

_____
Parent/Guardian (circle one) Date

_____
Witness Date

Family Physician Information

_____ _____
Name Phone Number

_____
Address

Insurance Information

_____ _____
Company Name Policy Number

Medical Information Please print and be thorough.

Chronic or existing medical conditions

(E.G., Asthma, Seizures, Diabetes)

_____

_____

Known Allergies:

Anesthetics	Insect Stings	Penicillin
Aspirin	I.V.P. Dyes	Shellfish
Codeine	Morphine	Tetanus Toxoid
Demerol	Novocain	
Antibiotics (Please List)		

Other (Please List)

_____

Current Daily Medications

_____

_____

Recent Shots and Vaccines

Tetanus/Date

Other/Date