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

CHILD’S NAME

print name here
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)

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