PARENT CONTACT INFORMATION

Please print.

Mother's Name:

_____

Phone: _____

Email: _____

Father's Name:

_____

Phone: _____

Email: _____

Legal Guardian (if applicable):

_____

Phone: _____

Email: _____

Logansport Memorial Hospital complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex (including sexual orientation and gender identity), age or disability.

LOGANSPORT Memorial HOSPITAL

1101 Michigan Avenue
Logansport, IN 46947
(574) 753-7541
LogansportMemorial.org

Parent Consent Form

CONSENT FOR MEDICAL TREATMENT OF MINORS

LOGANSPORT Memorial HOSPITAL

When you're away,

make plans for your kids

If you are going to be away from your children—for short-term travel, a planned trip, etc.—you want to make sure their healthcare needs can be taken care of, too. This form will be very important if your child were to become ill or injured while you are away or not with them at the moment it happens.

If you have a daily caregiver for your child (i.e. a babysitter or daycare) please make sure you have completed this form for them.

If your child is leaving home without you (i.e. going away to camp, participating in an out-of-town sporting event, traveling with someone other than yourself) please make sure you have completed this form and send it with your child.

You must complete a separate form for each child. Once completed, provide copies of the form(s) to every person who is responsible for your child or children.

By completing this form and providing the proper signatures, you are granting permission or giving consent for Logansport Memorial Hospital and our medical staff to provide medical assistance to your child when that child is under someone else's care.

CONSENT FOR TREATMENT

Name of Child: _____

Date of Birth: _____

Address: _____

City/State/Zip: _____

The caregiver below is authorized to consent for all medical and/or surgical treatment, and/or other medical procedures for the above named child, which may be required during my absence.

Caregiver Name: _____

The adult you are giving supervisory responsibility over your child

Address: _____

City/State/Zip: _____

Phone: _____

This consent serves as permission for treatment by Logansport Memorial Hospital, its associates and physicians. **(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 from or until:

Date Range: _____

If no date range is listed, this authorization shall terminate one year from today's date.

_____

Signature: Parent / Guardian (please circle one) *Date*

_____

Signature: Parent / Guardian (please circle one) *Date*

_____

Witness (must be an adult—age 18 or older) *Date*

MEDICAL INFORMATION

Any chronic or existing medical conditions:

_____

_____

_____

Current Medications: _____

_____

Date of last Tetanus Booster: _____

Known Allergies (please list):

Medications: _____

Examples: Amoxicillin, Anesthesia, Aspirin, Codeine, Cortisone, Morphine

Food: _____

Examples: Peanut Allergy, Tree Nut Allergy

Environmental: _____

Examples: Insect Stings

Other: _____

PROVIDER + INSURANCE INFORMATION

_____

Child's Physician or Provider Name

_____

Insurance Company Name

_____

I.D. (Policy) Number