If you are going to be away from your children, you want to make all the necessary provisions for their care. To help with these arrangements, Logansport Memorial Hospital provides this consent form and medical information questionnaire. This form will be very important, should your child become ill or injured while you are away.

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

The same is true if your child is leaving home without you—like going away to camp, participating in an out-of-town sporting event, or traveling with someone other than yourself. The information you provide in advance will be helpful—maybe even required—to give your child **prompt medical attention** if he or she needs it.

Next Steps:

1) Fill out the form as completely as possible for each of your children.
2) Give the completed form to the person or persons responsible for your children. Make sure the form is placed in a safe, accessible spot.
3) If medical care is necessary, the caregiver should take the consent form with the child to the hospital or doctor.

Additional copies of this form are also available in your provider's office. The hospital website also has a version available for download on any of these pages:

- http://www.logansportmemorial.org/family-medicine/
- http://www.logansportmemorial.org/pediatrics/
- http://www.logansportmemorial.org/patients/

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

Español (Spanish) — ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1 (574) 753-7541** or **1 (800) 243-4512**.

(Burmese) — သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် **1 (574) 753-7541** or **1 (800) 243-4512** သို့ ခေါ်ဆိုပါ။

LOGANSPORT Memorial HOSPITAL

Consent for Medical Treatment of Minors

LOGANSPORT Memorial HOSPITAL

1101 Michigan Avenue
Logansport, IN 46947

LogansportMemorial.org

Appointment of Health Care Representative for Child

(This document does not preclude any other authorized person from consenting to medical care for the child identified below, including any natural parent—including the parent signing below—or other authorized person.)

The undersigned, pursuant to I.C. 16-36-1-6 hereby appoints _____,
of lawful age, as my representative for the purpose of authorizing and consenting to hospital care and/or medical evaluation, care, and treatment (including diagnostic studies and interventions, including elective surgery) of my child listed below for any condition, illness, or injury or any routine examination while my child is in the temporary custody of the appointee.

Name of Child _____ Date of Birth _____

Medical Provider _____ Physician's Phone Number _____

Medications _____ Allergies _____

Health Problems _____ Date of Last Tetanus Booster _____

Insurance Company _____ Insurance Policy No. _____

(Please attach a copy of your insurance card)

I understand that this document shall remain valid and in force until the date indicated below, and that it is my obligation to notify any health care provider who may rely upon this form if I withdraw permission for my representative to consent to treatment or if I revoke my representative's power. I hereby release any health care provider furnishing medical or hospital care or treatment in reliance upon the consent of the above appointee from any liability arising from any claim that the above appointee was not authorized to consent to such care.

This authorization is to cover a period of time from _____ to _____.

Dated this _____ day of_____ , 20____.

_____

Signature of Parent/Person in Loco Parentis/Adult Sibling

NAME _____

ADDRESS _____

PHONE _____

EMAIL _____

Name/Address/Phone/Email of Parent
Person in Loco Parentis/Adult Sibling

This document must be signed in the presence of a witness **OR** acknowledged by a notary public.

Witness Name _____

Address _____

_____

_____

Phone _____
Home and Cell

OR

State of Indiana

County of Cass

This instrument was acknowledged before me on this

____ day of _____, 20____.

By _____

Notary Public: _____