PARENT CONTACT INFORMATION

Please print.

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.

Mother's Name:				
Phone:				
Email:				
Father's	Name:			
Phone:				
Email:				
	uardian (if applicable):			
Phone:				

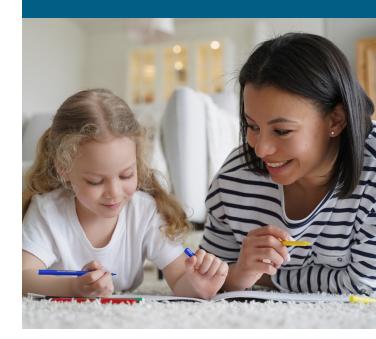


1101 Michigan Avenue Logansport, IN 46947 (574) 753-7541

LogansportMemorial.org

Parent Consent Form

CONSENT FOR MEDICAL TREATMENT OF MINORS





CONSENT FOR TREATMENT

MEDICAL INFORMATION

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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.

Name of Child:		Any chronic or existing medical conditions:
Date of Birth:		
Address:		
City/State/Zip:		
The caregiver below is authorized to cons and/or surgical treatment, and/or other n for the above named child, which may be absence.	nedical procedures	Current Medications:
Caregiver Name:		Date of last Tetanus Booster:
The adult you are giving super your child		Known Allergies (please list):
Address:		Medications:
City/State/Zip:		Examples: Amoxicillin, Anesthesia, Aspirin, Codeine, Cortisone, Morphine
Phone:		Food:
This consent serves as permission for trea Logansport Memorial Hospital, its associa (Note: Consents are not required in eme l agree to pay for all services provided to p absence. This authorization shall be effect	ites and physicians. rgency situations.) my child in my	Environmental: Examples: Insect Stings Other:
Date Range: If no date range is listed, this authorization shall t today's date.		PROVIDER + INSURANCE INFORMATION
Signature: Parent / Guardian (please circle one)	Date	Child's Physician or Provider Name
Signature: Parent / Guardian (please circle one)	Date	Insurance Company Name
Witness (must be an adult—aae 18 or older)	Date	I.D. (Policy) Number