MEDICAL INFORMATION

CHRONIC OR EXISTING MEDICAL CONDITIONS (I.E. ASTHMA, EPILEPSY, DIABETES)

____

____

____

____

RECENT SHOTS AND VACCINES

Tetanus/DPT & Date ______________

Other & Date ______________

____

____

CURRENT DAILY MEDICATIONS

____

____

____

____

KNOWN ALLERGIES

Medications	Food/Other
○ Anesthetics	○ Eggs
○ Antibiotics	○ Fish
______________	○ Insect Stings
______________	○ Latex
○ Aspirin	○ Milk
○ Codeine	○ Peanuts
○ Cortisone	○ Shellfish
○ Demerol	○ Soy
○ Morphine	○ Tree Nuts
○ Penicillin	○ Wheat
○ Tetanus Toxoid	○ Other ______________
○ Xray Dyes	______________
○ Xylocaine/Novacaine	______________
○ Other ______________	______________
______________	______________

HENDRICKS.ORG
(317) 745-DOCS

EMERGENCY DEPARTMENT
Danville - (317) 745-3450

IMMEDIATE CARE
Avon - (317) 272-7500
Plainfield - (317) 839-7200

Hendricks Regional Health

HENDRICKS REGIONAL HEALTH

PARENTAL CONSENT / MEDICAL RELEASE FORM

HENDRICKS.ORG

PROTECT YOUR CHILDREN

When your child is with another caregiver, you know they are in good hands – but what if a medical situation arises? It is important to make sure to give all caregivers permission to seek medical assistance for your children.

By completing this form you are granting permission for Hendricks Regional Health to provide medical assistance if it becomes necessary when your child is being cared for by someone else.

Please provide all requested information. You must complete a separate form for each child. Then, give copies of the form to every person who is responsible for caring for your child.

If your child is under the care of a minor (under age 18), the minor's parents must have authorization to give consent for medical treatment.

Please Note: Physicians have discretion regarding certain medical procedures, and may require direct parental consent before performing them.

CONSENT FOR TREATMENT

TO WHOM IT MAY CONCERN (PLEASE PRINT CLEARLY)

DEPENDENT NAME ______________________ BIRTHDATE ______________________

I (we) ______________________ (parent name) and ______________________ (parent name)

of ______________ (city), ______________ (county), ______________ (state)

grant permission for Dr. ______________________ and/or Hendricks Regional Health emergency department and/or Immediate Care Centers to provide medical care as deemed necessary to the above named dependent while being cared for by ______________________ (caregiver name), effective from __________ (date) through __________ (date).

If the person caring for child is a minor (under age 18), I grant permission for the minor's parent/guardian, ______________________ (minor caregiver's parent/guardian name), to request and authorize in writing, or as otherwise requested by doctor and/or Hendricks Regional Health, any and all examinations, medical treatment and/or procedures to or for the above named minor, either on or off the premises of Hendricks Regional Health, as may be deemed advisable or appropriate by any physician or surgeon licensed to practice medicine in the State of Indiana.

FAMILY PHYSICIAN

Name ______________________

Address ______________________

____

Phone ______________________

SIGNATURES (MUST BE COMPLETED)

____
parent/guardian and date

____
parent/guardian and date

____
address and zip code

____
witness and date

INSURANCE COMPANY

Insurance Co. ______________________

Address ______________________

____

Phone ______________________

Policy Holder Name ______________________

Policy No. ______________________

Group/Account No. ______________________

(PLEASE COMPLETE REVERSE)