



**Lutheran  
Health Network**  
**Lutheran Children's Hospital**

LutheranChildrensHospital.com

# PARENTAL CONSENT FORM

## ▶ Consent for medical treatment

**DID YOU KNOW THAT, IN YOUR ABSENCE, NO ONE CARING FOR YOUR CHILDREN CAN AUTHORIZE MEDICAL CARE WITHOUT YOUR WRITTEN PERMISSION?** If you leave your child with a sitter while you are working or traveling, complete this form, have it witnessed and leave it with your caregiver. This will ensure that, in an emergency, your child will receive prompt, necessary medical care even if you are not there. The caregiver should have this form available if a child requires medical treatment without the parent/guardian present.

**CALL 911 IN AN EMERGENCY.**

Make copies of blank form for future use.  
Can be used at any healthcare facility.

I (We), \_\_\_\_\_ and \_\_\_\_\_  
(parent/guardian name) (parent/guardian name)  
of \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ do hereby state  
(city) (county) (state)  
that I am (we are) the parent(s) or legal guardian(s) of \_\_\_\_\_,  
(name of child)  
a minor, age \_\_\_\_\_, born on \_\_\_\_\_,  
who resides with me (us) at \_\_\_\_\_  
(street address)  
\_\_\_\_\_  
(city, state, zip)

I (we) authorize \_\_\_\_\_, an adult  
(name of caregiver)  
over 18 years of age, who resides at \_\_\_\_\_ in the city of  
(address of caregiver)  
\_\_\_\_\_, state of \_\_\_\_\_, to consent to any  
necessary examination, anesthesia, surgery, treatment and/or hospital care to be rendered to the above-named minor  
under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in  
the state(s) of \_\_\_\_\_

for the period \_\_\_\_\_ to \_\_\_\_\_  
(specific date) (specific date)

Today's date: \_\_\_\_\_

**SIGNATURE(S) OF PARENT(S) OR GUARDIAN(S):**

▶ \_\_\_\_\_ ▶ \_\_\_\_\_

Witness: \_\_\_\_\_ Witness: \_\_\_\_\_

**PARENT(S)/GUARDIAN(S) CONTACT NUMBERS:**

Cell: \_\_\_\_\_ Other: \_\_\_\_\_  
Cell: \_\_\_\_\_ Other: \_\_\_\_\_

Child's physician: \_\_\_\_\_  
Phone: \_\_\_\_\_

Allergies (including medications):  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL INSURANCE**

Insurance name: \_\_\_\_\_  
Insurance phone: \_\_\_\_\_  
Policyholder's name: \_\_\_\_\_  
Identification number: \_\_\_\_\_  
Group/policy number: \_\_\_\_\_

Chronic/existing diseases or medical problems:  
\_\_\_\_\_  
\_\_\_\_\_  
Medications: \_\_\_\_\_  
Date of last tetanus injection or booster: \_\_\_\_\_