FIRELANDS
Regional Medical Center

Consent for Emergency Treatment

I (We) the undersigned parents or legal guardians of:

Name:____

DOB:______________________ Weight:____________ Last Tetnus:____________

Allergies:____

Medications:____

Pertinent Health History:____

____

Family Physician/Pediatrician:____

Medical Specialists:______________________ Previous visits to FRMC? (Y/N)________

Health Insurance Co.:______________________ Policy Number:______________________

Do here by authorize:______________________ Relationship:______________________*

The above signed caretaker to consent to the treatment and or hospitalization of child by an emergency medical physician on staff at Firelands Regional Medical Center in case of any accident or illness that may arise in my (our) absence or unavailability.

*Denotes a specific person or agency you may allow to consent to your child's treatment.

Signature of Parent/Legal guardian (s):

Mother:______________________________ Witness:______________________

Date____________20___ Phone: home-__________________ work-__________________

Address:____

City:______________________ State:________________ Zip:____________

Father:______________________________ Witness:______________________

Date____________20___ Phone: home-__________________ work-__________________

Address:____

City:______________________ State:________________ Zip:____________

Legal Guardian:______________________________ Witness:______________________

Date____________20___ Phone: home-__________________ work-__________________

Address:____

City:______________________ State:________________ Zip:____________