PARENTAL CONSENT FOR EMERGENCY MEDICAL/SURGICAL TREATMENT AND MEDICAL INFORMATION FORM

In presenting my (our) child for diagnosis and treatment

Name:_____
Son ( ) Daughter ( )

Born_____ ; I/ We as parents/guardians

Name:_____
Mother ( ) Father ( ) Legal Guardian ( )

hereby voluntarily consent to the rendering of such care and medical treatment, including diagnostic procedures and blood transfusions, by authorized prehospital personnel and members of the hospital staff, as may in their professional judgment be necessary or in the best interest of my child.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on child's condition.

I have read this form and I certify that I understand its contents.

In addition I/we hereby give my (our) consent to:

Y.A.C.B. Academy of Dance / Ballet Continental
(Name of person/agency)

who will be caring for my (our) Son/Daughter

for the period 08/01/2019 to 06/30/2020 to arrange for routine or emergency medical/dental care and treatment necessary to preserve the health of my (our) child.

I/we acknowledge that I am (we are) responsible for all reasonable charges in connection with care and treatment rendered during this period.

Signature_____
Mother ( ) Father ( ) Legal Guardian ( )

Date: _____

Witness:_____

Date:_____

Comments_____

_____

_____

Hospital preference:_____
(if stable)

Parent Information

Name:_____

Address:_____

Telephone # _____

Emergency Contact:_____
Phone:_____

Emergency Contact:_____
Phone:_____

Insurance Information

Name of Carrier:_____

Policy # _____

Physician Information

Pediatrician:_____

Telephone # _____

Family Physician:_____

Telephone # _____

Surgeon:_____

Telephone # _____

Dentist:_____

Telephone # _____

Medical Problems

_____

_____

_____

Medications:_____

_____

Allergies:_____

Date of last tetanus booster:_____