

## HOSPITAL MEDICAL INFORMATION

Attention Parents/Legal Guardians

Did you know that if your child has an accident or illness in your absence, except in cases of injuries which threaten life or limb, patients under 18 years of age must have a parent or legal guardian sign a consent form before treatment can be given in a hospital emergency room? You can save time and the concern of the person to whom you entrust the care of your child by completing and signing an authorization for examination and treatment of your child should this be necessary during your absence. It is important to include any allergy, illness history and medications that your child is taking as well as the name of the child's physician and last tetanus immunization. The emergency department staff at Day Kimball Hospital has devised a consent form for you to use. Just complete the form below and leave it with your sitter. Additional forms are available in the emergency department.

### DAY KIMBALL HOSPITAL EMERGENCY DEPARTMENT PATIENT CONSENT FORM

FULL NAME (PATIENT): \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS(HOME): \_\_\_\_\_ D.O.B.: \_\_\_\_\_

TELEPHONE #: \_\_\_\_\_ RELIGION: \_\_\_\_\_

PHONE # (VACATION): \_\_\_\_\_ PHONE# (WORK): \_\_\_\_\_

SOCIAL SECURITY # (PARENT OR GUARDIAN): \_\_\_\_\_ AUTO LICENSE: \_\_\_\_\_

CHILD'S SOCIAL SECURITY #: \_\_\_\_\_

NAME (PARENT OR GUARDIAN): \_\_\_\_\_

EMPLOYER (PARENT OR GUARDIAN): \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

GUARANTOR (NAME OF PERSON CARRYING INSURANCE): \_\_\_\_\_

FAMILY MEDICAL DOCTOR: \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

WILL YOUR CHILD NEED TO TAKE MEDICATION AT THE PROGRAM:      Yes      No

**If yes, an additional Medical Authorization form must be completed if child is to receive any medication during program hours. This includes epi-pens, prescriptions and over-the-counter medications. Please download the forms from our website at [www.thompsonrec.org](http://www.thompsonrec.org) or call 923-9440.**

ALLERGIES TO MEDICATIONS: \_\_\_\_\_

PERTINENT MEDICAL HISTORY: \_\_\_\_\_

LAST TETANUS IMMUNIZATION: \_\_\_\_\_

In the event your efforts to reach me are unsuccessful, I, parent or legal guardian consent to Emergency evaluation, treatment and/or admission to Day Kimball Hospital as determined by physician in charge of the care of the above named person.

DATED: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

CONSENT EXPIRES: \_\_\_\_\_

IT IS VITAL THAT YOU COMPLETE THE ABOVE FORM IN ITS ENTIRETY. PLEASE LIST ANY AND ALL ALLERGIES, MEDICAL CONDITIONS THAT THE STAFF SHOULD BE AWARE OF.