EXPIRES: _____

Family's Last Name Alternate Last Name

CONSENT FOR TREATMENT

To be prepared for any emergencies that may happen while you are away from home, simply complete and return this Consent for Treatment form. Adventist Hinsdale Hospital will keep the information on file to assure your child of immediate care should it be necessary in your absence. Every effort will be taken to reach you for medical treatment permission.

PLEASE PRINT (Use this form for up to 5 children)

Child's full legal name *(Last name first)*	Sex	Birth date	Date of DPT or Tetanus	Allergies

Patient Medical History (i.e. asthma, diabetes, heart problems):

The Emergency Services treatment will be covered by:

Policyholder's name Policyholder's birth date

Name of insurance company Insurance policy # Group #

Insurance mailing address City State Zip Code

Employer of policyholder

Employer's address City State Zip Code

School insurance policy [ ] Yes [ ] No

The aforementioned physicians represent an outstanding group of independent practitioners who chosen Adventist Hinsdale Hospital to admit and treat their patients.

Name of parent (or)

Name of guardian (please attach a copy of court orders)

Address City State Zip Code

Home phone (with area code)

Business phone (with area code)

Name of family doctor Phone (with area code)

I hereby give my consent to the Emergency Services staff of Adventist Hinsdale Hospital to treat my child/children in an emergency when it is impossible to reach me personally. I understand that this form is legally acceptable for one year and will be discarded at that time.

SIGNATURE DATE

The signature above authorizes the assignment of all insurance benefits to Adventist Midwest Health and to such independent groups of physicians that the hospital system has entered into agreement to provide specialized services. The signature above hereby authorizes the hospital to release medical records and other information concerning this hospitalization or outpatient visit for the purpose of utilization, quality control and/or insurance benefits and/or payment.

Name(s) of close relative(s) in case parent cannot be reached:

Name/relationship Phone (with area code)

Name/relationship Phone (with area code)

Name/relationship Phone (with area code)