HOSPITAL PERMISSION TO TREAT

Child's Name_____ Birthdate _____
Address _____
_____
Family Physician _____ Phone _____
Family Dentist _____ Phone _____
Town where above practice_____
Medical Allergies _____
Medication child is currently taking _____
_____
Date of last tetanus shot _____
Parent's Name _____
Parent's Address _____
Home Phone _____ Work Phone _____
Responsible adult in parent's absence:
Name _____ Phone _____

This is to certify that I, the undersigned, consent to and authorize the performance of all treatment, operations, and administration of anesthetics which, in the judgment of the attending physician, may be deemed necessary.

Signed _____ Date _____

CONFIDENTIAL INFORMATION FORM

Does your child have any allergies which require special diets or medical treatment? _____ Explain _____
_____
Are there foods to which the child is allergic?_____
_____
Does your child have any special health problems? _____
_____
Please share information about child's fears, problems or special needs that may help us minister to your child. _____
_____
_____
_____
What kind of insurance do you have? _____