



Center Community Hospital
PARENTAL CONSENT
FOR THE TREATMENT OF
MINORS IN THE
EMERGENCY/OUTPATIENT
DEPARTMENT

In the event that I am unavailable for purposes of providing parental consent, I hereby authorize the physician(s) and staff in the Emergency/Outpatient Department of Center Community Hospital to provide such hospital care that includes routine diagnostic procedures and medial treatment as necessary to my minor son/daughter.

Full Name

I understand that the consent and authorization herein granted does not include major surgical procedures.

This consent is valid for one year from the date indicated below. Photostatic or carbon copy of this authorization shall be considered as effective and valid as the original.

Physical conditions of the minor noted above that the physician should be aware of: (Allergies, recurring illnesses, disabilities, chronic illnesses, etc.)

I understand that I will be contacted as soon as possible in the event that my child is brought to the Hospital for treatment. If I am not available, please contact:

_____ Telephone: _____

My family's physician id Dr. : _____

Printed Full Name

Signature of Parent/Guardian

Date

Telephone: _____

Home: _____

Work: _____