EMERGENCY ROOM CONSENT FORM

Print and complete this form, then return to DCH Emergency Department.

CONSENT TO EMERGENCY CARE

Consent for emergency medical treatment of minors temporarily separated from their parents or guardians.

Time Period: From: ____ through ___________________________________

Minor's Information:

Name: ____ Social Security Number: _________________________

Date of Birth: _________________________________Home Phone: ____

Address: ____ City/State/Zip: _____________________________________

Next of Kin:

Mother's Full Name: ____ Work Phone Nmber:______________________

Father's Full Name: ____ Work Phone number: _____________________

Name of Insurance: ___________________________________ Name of Policy Holder: __________________________

Group Number: ____ Benefit: ______________________________________

____

Family or Personal Physician: ____________________ City: ___________ Phone: __________

Surgeon: ____________________ City: ___________ Phone: __________

____

Medications or Medical Disorders (include any medications prescribed in recent weeks and any recent illnesses).

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Name(s) of people responsible to sign for the above named child as designated by parents:

Name (please print): ____

Name (please print):____

I understand and agree that I am responsible for any and all costs and expenses for emergency care and/or medical care in treatment rendered to the above named minor. I understand that I will be billed for these services and I may assign benefits to Daviess Community Hospital due under insurance carrier.

Print Name (Father or Legal Guardian): _______________________________________

Signed: ____ Date: _____________________

Print Name (Mother or Legal Guardian): _______________________________________

Signed ____ Date: _____________________

Complete and mail/bring to Daviess Community Hospital Emergency Department.

Office ONLY: Original to HIM, one copy to Emergency Services, one copy to Admitting Office.