Protecting Your Children

Although you may have someone caring for your children while you are away, it is a good idea to make sure their health care needs are met, in the case of an emergency.

By completing this form and providing all of the proper signatures, you are granting permission for Putnam County Hospital and our medical staff to provide medical assistance to your child when that child is in someone else's care.

Please be thorough and complete all of the information. You must complete a separate form for each child. Once complete, please provide a copy of the completed form to every person who is responsible for caring for your child. Also, remember to send along a form when your child is going away, whether it is to travel, to a camp, or other circumstances.

NOT ALL FACILITIES WILL ACCEPT THIS FORM.

If your child is under the care of a minor (under 18 years of age), the minor's parent/guardian must have authorization to give consent for medical treatment.

PLEASE NOTE:
The provider treating your child has the discretion to request direct parental consent prior to administering treatment.

Putnam County Hospital

Celebrating 90 Exceptional Years

1542 S. Bloomington St. | Greencastle, IN 46135
765.653.5121 | www.pchosp.org

Putnam County Hospital
PHYSICIAN PRACTICES

PARENTAL CONSENT FORM

Protecting your children when you can't be by their side

Consent for Treatment

_____
Dependent's Name

_____
Date of Birth

To Whom It May Concern:

I, _____
parent/guardian

and, _____
parent/guardian

of _____
address line 1

_____
address line 2

grant permission to provide medical care as deemed necessary to:

_____
caretaker's name

Effective from:

_____through _____
date date

If the person caring for my child is a minor (under the age of 18), I then grant permission for the minor's parent/guardian:

_____

MEDICAL INFORMATION:

Chronic or Existing Medical Conditions:

_____

_____

Known Allergies:

_____

_____

Medications and Doses:

_____

_____

_____

_____

Vaccines:

Tetanus/Date:_____

DPT/Date:_____

Other/Date:_____

OTHER IMPORTANT INFORMATION:

_____

_____

_____

_____

INSURANCE INFORMATION:

Company Name:_____

ID/Policy #:_____

Address of insurance company:

_____

_____

_____

Family Physician:_____

Address of family physician:

_____

_____

_____

Phone #:_____

Parent/Guardian Signatures

_____

_____

Phone #'s where you can be reached:

_____

_____

THIS FORM MUST BE WITNESSED TO BE VALID:

Witness:_____

Date:_____