



Broadway at 11th Street • Quincy, Illinois 62301

CONSENT FOR TREATMENT OF MINOR CHILD(REN)

Children for Whom Consent is Given
1. Child's Full Legal Name Birthdate Name of Child's Physician
Allergies Medical Problems
2. Child's Full Legal Name Birthdate Name of Child's Physician
Allergies Medical Problems
3. Child's Full Legal Name Birthdate Name of Child's Physician
Allergies Medical Problems
If more children, complete an additional form.

Name(s) of Parent(s): Home Phone:

Address:

Mother's Work Phone: Employer: Hours:

Father's Work Phone: Employer: Hours:

Persons or places through which you could be located in an emergency: 1. Phone: 2. Phone:

As the parent(s) of the minor child(ren) listed above, I (we) hereby consent to any radiology or laboratory test, medical or surgical treatment, or hospital service rendered to my (our) minor child(ren) under the care of any qualified physician on the Blessing Hospital Medical/Dental Staff.

My (our) consent is given in advance of a specific medical diagnosis or treatment that may be required and is given to encourage each physician to exercise his/her best judgement in ordering tests or treatment appropriate to the medical needs of the child(ren).

This consent is effective on the date below and will be updated if the medical history or information on the child(ren) or parent(s) changes.

Signature of Father Signature of Mother

Effective Date Witness

(We recommend you update your child(ren)'s records annually.)

Mail completed form to: Blessing Hospital - Emergency Center, PO Box 7005, Quincy, IL 62305