McDonough District Hospital

525 East Grant Street, Macomb, IL 61455
(309) 833-4101
www.mdh.org

AUTHORIZATION TO TREAT A MINOR (under age 18)

Suppose your child needed medical care while you were not available. Without your consent, an emergency room can do little unless a life-threatening condition exists. By signing this consent form, your child will receive medical care even if the situation is non-emergent.

In the event my child is presented to the Emergency Room for examination, diagnosis and treatment, I/we the undersigned parent/s or legal guardian of (child's name) _____, a minor, do hereby voluntarily consent to allow authorized members of McDonough District Hospital's staff to use their professional judgment and render care to my child as they determine necessary. This care may include diagnostic procedures and appropriate surgical and medical interventions. I/we acknowledge that no guarantees have been made as to the effect of such treatment on my child's condition.

I/we further acknowledge that I am/we are responsible for all reasonable charges in connection with the care and treatment rendered during this period. When applicable, I/we authorize McDonough District Hospital and the physicians providing treatment to release medical information, as necessary, to insurance carriers designated in order to bill the account to the insurance carrier for consideration of payment.

Parent/Guardian signature	Relationship	Date

NOTE: This form is valid for one year from date of signing. Please complete a new form after that time.

- ***In case of emergency, I can be reached at:***

Home phone	Work phone	Other

- ***Others that could be notified in my absence:***

Name	Phone
Name	Phone

Child's Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____

Allergies: _____

Medications: _____

_____

Chronic health problems: _____

_____

Date of last tetanus shot: _____