Consent for Medical/Surgical Care/Emergency Treatment and Child's Medical Information

In presenting my son/daughter for diagnosis and treatment

Name: _____ for_____
☐Mother ☐Father ☐Legal Guardian ☐Son ☐Daughter

of _____ years of age, hereby voluntarily consent to the rendering of such are, including diagnostic procedures, surgical and medical treatment and blood transfusions, by authorized members of the hospital staff or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition.

I have read this form and certify that I understand its contents.
We/I hereby give our (my) consent to: Savannah Association For The Blind, INC. dbc SCBLV

who will be caring for our (my) child:
_____
(Name of Child)

for the period _____ to _____ to arrange for routine or emergency medical/dental care and treatment necessary to preserve the health of our (my) child.

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period.

Name: _____ Family physician: _____
Address: _____ Pediatrician: _____
_____ Surgeon: _____
Telephone no.: _____ Orthopedist: _____

Health insurance carrier: _____ Child's allergies, if any: _____
Group no.: _____ _____
Date of last tetanus booster: _____
Medicines child is taking:_____
_____
_____

Signature: _____ Date:_____
Mother, Father or Legal Guardian
Witness: _____ Date: _____
In case of emergency I can be reached at:
_____
_____