



Hope Visitation & Exchange Center

1132 West Market Street

Lima, OH 45805 Ph. 419-221-2118 Fax. 419-221-3932

Consent for Emergency Medical Treatment

Child's Name _____ DOB _____ Sex: M ___ F ___

Child's Address _____

Custodial Parent or Guardian's Name: _____

Address _____

Home Phone _____ Cell Phone _____

Place of Employment _____ Work Phone: _____

Alternate contact person: _____ Phone: _____

Relationship to child: _____

Family Doctor _____ Phone: _____

Family Dentist _____ Phone: _____

The hospital or doctor not having access to the medical history of the child needs the following information:

Medication being taken: _____

Bleeder or Hemophilia? _____

Date of last tetanus shot? _____ Physical Impairments? _____

Allergies/Reactions? _____

Other Important Information: _____

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I hereby give my consent to and authorize the administration of any medical and/or dental treatment deemed necessary for my child and further, consent to and authorize the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists concur in the necessity of such surgery and are obtained prior to the performance of such surgery.

Parent or Guardian Date

SWORN TO ME AND SUBSCRIBED TO IN MY PRESENCE THIS _____ DAY OF
_____, 200__.

Notary Public

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