McDonough District Hospital

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

AUTHORIZATION TO TREAT A MINOR (under age 18)

State law prohibits hospitals from treating minor children, <u>except in life-threatening situations</u>, without first obtaining permission from the child's parents or legal guardian. This law is designed to protect all parties involved, but it can result in delays while hospital personnel attempt to locate a child's parent. By completing this form, care is provided without delay.

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

- ***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

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

<u>Child's Information</u>

Name: ______________________

Address: ______________________

City: __________ State: _____ Zip: _______

Date of birth: ______________________

Allergies: ______________________

Medications: ______________________

____

Chronic health problems: ______________________

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Date of last tetanus shot: ______________________