Chandler Regional Medical Center
Mercy Gilbert Medical Center
Members of CHW

DEAR PARENT OR LEGAL GUARDIAN

When you leave home, it's important to provide for your child's protection. This involves more than just arranging for a sitter – you should also leave written authorization for a responsible adult to consent to medical treatment in your absence.

Unless a child's injuries are life threatening, hospitals are required by law to have permission from a parent or guardian before treating children under age 18. It is our policy to always attempt to reach the child's parent(s).

When you go out of town and leave your child in someone else's care, you should complete a consent form. The form should be given to the adult with a copy of your insurance card in the event your child needs medical care while you're away.

A separate form is needed for each child. You should fill out a new one each time you go out of town.

CHANDLER REGIONAL MEDICAL CENTER

475 S. Dobson Road, Chandler, Arizona 85224
480.728.3000 | www.chandlerregional.org

MERCY GILBERT MEDICAL CENTER

3555 S. Val Vista Drive, Gilbert, Arizona 85297
480.728.8000 | www.mercygilbert.org

CHW URGENT CARE IN AHWATUKEE

4545 E. Chandler Boulevard, Phoenix, Arizona 85048
480.728.4000

CHW URGENT CARE IN GILBERT

1501 N. Gilbert Road, Gilbert, Arizona, 85203
480.728.4100

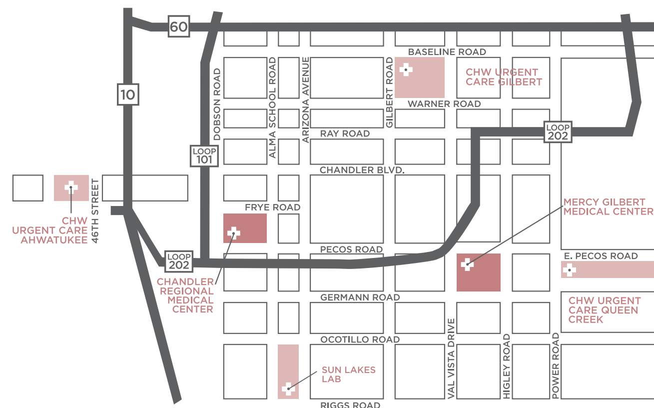
CHW URGENT CARE IN QUEEN CREEK

7205 S. Power Road, Queen Creek, Arizona, 85295
480.728.6000

SUN LAKES LAB

10440 East Riggs Road, Sun Lakes, Arizona 85248
480.728.4250

For a free physician referral, please call the ResourceLink at 1.877.728.5414 or e-mail ResourceLink@chw.edu.



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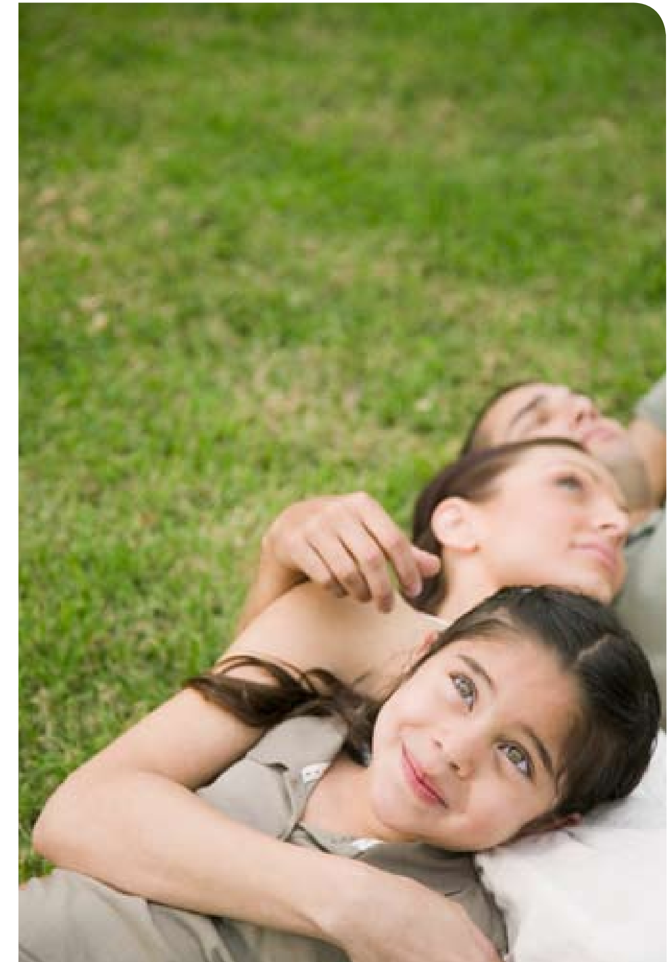

WHILE YOU ARE AWAY

Medical Consent Form for Minors

IT'S ABOUT LIFE®

AUTHORIZATION TO CONSENT TO MEDICAL OR SURGICAL TREATMENT OF A MINOR

I (We), the undersigned parent(s) or legal guardian(s)

of .... ,
name

date of birth .... , do hereby

authorize .... ,
name

(........) .... ,
phone

....
address

to consent on my (our) behalf to any medical treatment, hospitalization or surgery for said child, if I (we) the parent(s) or legal guardian(s) cannot be reached.

It is understood that this authorization is given in advance of any specific hospitalization, medical treatment or specific consent on my (our) behalf and any treatments or attention given under the exercise of the authorized be in the best judgement deemed necessary.

I (We) will be responsible for charges resulting from any medical treatment, surgery or hospitalization rendered under this authorization.

WHO TO CALL IN AN EMERGENCY

List two people to contact in case of an emergency:

1. ....
name and relationship to family

....
phone and address

2. ....
name and relationship to family

....
phone and address

MY CHILD'S PHYSICIAN IS:

....
name

....
phone

....
address

THE HOSPITAL/MEDICAL CENTER I (WE) PREFER IS:

....
name

....
phone

....
address

DURING OUR ABSENCE, I (WE) MAY BE REACHED AT:

....
phone

....
address

This consent shall remain in effect during the dates

of .... to .... unless cancelled in

writing by the undersigned before that date.

Signed this .... day of

...., 20 ....

....
parent/guardian signature

....
witness signature

MEDICAL INFORMATION

List any restrictions for medical/surgical treatment

....

Date of last tetanus ....

Allergies to food or drugs ....

....

Medications child is currently taking ....

....

List any special medical problems or conditions

....

CHILD'S DENTIST

....
name

....
phone

....
address

INSURANCE INFORMATION

(Please include a copy of your insurance card)

Policy holder's name ....

Policy holder's employer ....
name

....
phone

....
address

Relationship to patient ....

Policy number ....

Group number ....