Illini Hospital
321 W. Washington Street
Pittsfield, IL 62363

CONSENT FOR TREATMENT OF A MINOR CHILD

CHILDREN (1) _____ BIRTHDATE _____
(2) _____ BIRTHDATE _____
(3) _____ BIRTHDATE _____
(4) _____ BIRTHDATE _____
(5) _____ BIRTHDATE _____

PARENT/GUARDIAN'S NAME _____ HOME PHONE _____
ADDRESS _____
MOM'S WORK PHONE _____ HOURS _____
MOM'S CELL PHONE _____ DAD'S CELL PHONE _____
DAD'S WORK PHONE _____ HOURS _____
EMERGENCY NUMBERS _____ _____

We, the undersigned parents/guardians of the above minor children, do hereby consent to any x-ray, examination, medical and/or surgical diagnosis or treatment and hospital service that may be rendered to said minor(s) under the general or special instructions of the below named physician or any other qualified M.D. on staff at Illini Hospital.

It is understood that this consent is given in advance to any specific diagnosis or treatment being required but is given to encourage the Doctor to exercise his or her best judgement as to the requirements of such diagnosis or treatment.

This consent shall remain effective from date hereof until one year from the date and will be updated by the parent if medical history of the child changes. A photocopy of this authorization shall be valid as the original.

_____ _____
DATE PARENT/GUARDIAN'S SIGNATURE

ALLERGIES: _____

_____ _____
WITNESS

MEDICAL PROBLEMS: _____ CHILD'S PHYSICIAN _____
ADDRESS _____
_____ PHONE _____

Note to Parents:
If you choose, you may fill out this form and return it to the school. Our school nurse will then take it to the hospital for them to keep on file in case of an emergency when you cannot be reached. This form must be filled out each year.