PARENTAL CONSENT TO EMERGENCY MEDICAL/DENTAL TREATMENT

I/We, the undersigned, parent(s) or guardian(s) of ________________________________, a minor, do hereby consent to any examination, anesthetic, medical or surgical diagnostic or therapeutic procedure deemed advisable by, and to be rendered by or under the supervision of a licensed physician on the medical staff of Blank Children's Hospital, Iowa Methodist Medical Center, Methodist West Hospital or Iowa Lutheran Hospital.

This general consent is given with the following limitations: ________________________________
____

It is understood that this consent is given in advance of any specific diagnosis or hospital care being required, but is given to authorize any and all such diagnosis, treatment or hospital care that such a physician in the exercise of his/her best judgment may deem advisable. This consent shall remain in effect until ____or until revoked by me/us in writing.

I/We understand that if our child needs to be transported to Iowa Methodist /Blank Children's Hospital by ambulance the UnityPoint Health Child Development Center will call for the ambulance.

I/We agree to pay all charges and fees incurred in provision of emergency medical diagnosis and treatment pursuant to this consent, and to hold harmless the UnityPoint Health Child Development Center and its staff for any treatment deemed advisable and administered pursuant to this consent.

Dated ___________________ Father's Signature ____

Dated ___________________ Mother's Signature ____

Dated ___________________ Legal Guardian Signature ___________________________________

Child's Name ______________________________________ Phone (_____) _________________

Address ____

Health Insurance Carrier _____________________________ Policy No. ____________________

Dental Insurance Carrier _____________________________ Policy No. ____________________

Telephone numbers where parents or guardian may be reached:

Father's Name ____

Home (_____) __________________________ Business (_____) ___________________________

Mother's Name ____

Home (_____) __________________________ Business (_____) ___________________________

Guardian's Name ____

Home (_____) __________________________ Business (_____) ___________________________

Family Physician____

Office (_____) ____