**Current Daily Medications**

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

**Recent Shots and Vaccines**

Tetanus/Date ____________________________________________________________________
Other/Date ____________________________________________________________________

**Known Allergies**

- Anesthetics
- Antibiotics (Please List)
- Aspirin
- Codeine
- Demerol
- Insect Stings
- I.V.P. Dyes
- Morphine
- Novocaine
- Shellfish
- Tetanus Toxoid
- Other (Please List)
Child’s Name_____________________________________________Date of Birth ___________________________

Home Address___________________________________________   Home Phone # ________________________

City/State/Zip __________________________________________________________________________________

Caregiver’s Name _________________________________________ Phone # __________________________

Parental Contact __________________________________________ Phone # __________________________

(The adult given Supervisory Responsibility over a child by a parent or guardian)

The above named caregiver shall be authorized to consent for all medical and/or surgical treatment
and/or other medical procedures (including administration of anesthesia, blood transfusions, diagnostic
tests, etc.), for the above named child, which may be required during my absence. If circumstances permit,
I would like to have our doctor consulted in connection with such treatment.

Please attempt to contact me at the following number: ______________________________________

This consent serves as permission for treatment by St. Vincent, its associates and physicians.
(Note: Consents are not required in emergency situations.) The consent also shall include all procedures
for which consent or authorization is required under the policies of St. Vincent Hospitals and Health
Services. I agree to pay for all services provided to my child in my absence. This authorization shall be
effective until:

☐ a) ________________________________
☐ b) unless earlier revoked by me.

Signatures

Parent, Guardian (Circle One) Date

Parent, Guardian (Circle One) Date

Witness Date

Family Physician

Name

Address

Phone #

Insurance Information

Company Name

Policy Number

(Please Complete Reverse Side)