Parent Consent Form

To enable the Health Center of Indiana University and/or other health facilities in Bloomington to provide prompt care to your minor, we must have a completed consent form on file each year. This way, we can help your child without delay in an emergency.

(Please print or type)
Name of Minor____
Birthday (MM/DD/YY)____
Insurance Company (Do not omit this information) ____________________________________
Policy # or Group #____
Social Security # (If used by insurance company)_____________________________________
MEDICAL INFORMATION
Allergic Reactions____
Medication Presently Taking____
Date of Last Tetanus Toxoid (Do not omit this information)_______________________________
Past illness or other information that would be useful in the event treatment is necessary
____
____
____

EMERGENCY NUMBERS
Father-Home____
Mother-Home____
Father-Work____
Mother-Work____
Cell # that may be needed______________________________________
A phone number to call in case parents cannot be reached
Name____
Phone____

Please Check One of the Following Options and Sign
_____I grant permission to the director, assistants, or other persons responsible for his/her care to act on my behalf for said minor in granting permission of evaluation and treatment of medical problems. I understand that should a major medical problem arise, and attempt will be made to notify me by telephone. In the event that I cannot be reached, I hereby give my consent to such treatment as deemed necessary (including surgery, x-ray examination and anesthesia to be rendered to said minor by a licensed physician, nurse)
_____I authorize limited care as follows:
____
____
Full name of father__________________________________
Mother____
I,________________________________declare that I am the Father/Mother/Guardian of the above named minor (circle correct title)
Signature of Parent/Guardian____
Date______________________