

**CONSENT FOR MEDICAL/EMERGENCY  
TREATMENT**

I, \_\_\_\_\_ being the \_\_\_\_\_  
Parent/Legal Guardian's Name Relationship to child

of \_\_\_\_\_, hereby voluntarily consent to the  
Child's Name

rendering of such care, including diagnostic procedures, surgical and medical treatment, and blood transfusions, by authorized members of Pediatric Associates of Iowa City and Coralville, Mercy Hospital or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on child's condition.

I have read this form and I certify that I understand its contents.

I hereby give my consent to \_\_\_\_\_  
Name of Person/Agency

who will be caring for my child for the period of \_\_\_\_\_ to \_\_\_\_\_  
to arrange for routine or emergency medical care and treatment necessary to preserve the health of my child.

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

Parent's Name: \_\_\_\_\_ Pediatrician: \_\_\_\_\_

Address: \_\_\_\_\_ Child's Allergies: \_\_\_\_\_

\_\_\_\_\_ Date of Last Tetanus: \_\_\_\_\_

Telephone: \_\_\_\_\_ Medicines Child is taking: \_\_\_\_\_

Name of Health Insurance Carrier and \_\_\_\_\_  
Policy Number: \_\_\_\_\_

Signature: \_\_\_\_\_  
Mother, Father, Legal Guardian Date

Witness: \_\_\_\_\_  
Date