Emergency Treatment
Authorization for Minors

Mercy Children’s Hospital & Clinics
In the event you are not with your child when an emergency situation occurs, you should know that your child cannot receive treatment without your consent. When leaving your child in the care of others, a signed release form will help your child avoid an unnecessary delay of treatment. Neither grandparents, neighbors, brothers nor sisters can authorize medical care for your child. **Your written consent is required before your youngster can receive emergency treatment.** However, if a physician feels immediate care is necessary to prevent death or serious injury, treatment will begin.

To ensure immediate medical attention for your child in your absence, complete the information on the back of this brochure and leave it with your child’s caregiver.

**What to do in a medical emergency:**

1. Dial 911 if an ambulance is needed.
2. Call your family physician for emergency circumstances if time allows.
3. Go immediately to the Pediatric Emergency Department at Mercy Medical Center – Mercy Children’s Hospital and Clinics or the closest hospital of your choice.
Medical History

Child’s physician: _________________________

Phone: __________________________________

Date of last tetanus: ______________________

Child’s allergies: __________________________
_________________________________________
_________________________________________

Medications taken regularly (include dosage information): _____________________________
_________________________________________
_________________________________________
_________________________________________

Chronic illness/medical problems/prior hospitalization: ______________________________
_________________________________________
_________________________________________

Additional instructions: ______________________
_________________________________________
_________________________________________
As the parent and/or guardian, I authorize medical treatment by a physician in the event of an emergency. This authorization is granted only after a reasonable effort has been made to reach me.

Child’s name: ___________________________________________ Date of birth: _______________________________

Child’s home address: ________________________________________________________________________________

City: __________________________________________________________ State: ___________ Zip: ________________

Signature (parent or legal guardian) ______________________________________________  Date: ________________

Relationship to child: _________________________________________________________________________________

Home phone:  ________________________________________ Alternate phone:  _______________________________

Parent’s home address: ________________________________________________________________________________

City: __________________________________________________________ State: ___________ Zip: ________________

Label: _________________________________ Policy #:/Group #: _______________________________

OR

Medicaid #: __________________________________________________________________ State: ________________

Policy #:/Group #: __________________________________________________________________

State: ___________________________ Zip: ________________ Date: ________________

City: __________________________________________________________ State: ___________ Zip: ________________

Insurance Company: _________________________________

Same as childs ______________________________________________________________

Home and Business Address:

MercyChildrens
HOSPITAL & CLINICS

www.mercydesmoines.org/childrenscenter