Parental Consent Form

Protecting your children while you travel means more than getting a babysitter or a relative to watch them. To be safe, you should provide written authorization for a responsible adult to approve any necessary emergency medical treatment for your children when you are traveling without them or your children are traveling without you.

Unless a child’s injuries are life-threatening, hospital personnel and physicians cannot treat them without legal parental or guardian consent. As a result, your child may suffer unnecessary discomfort while waiting for you to be reached to approve stitching a cut or setting a broken arm.

Each time you or your child goes out of town without one another, complete the form and provide the information requested on the inside. A separate dated consent form is necessary each time you leave town. Please ask the adult you have designated on the consent form to keep it ready and available. It should be taken to the hospital or doctor’s office if a child requires medical treatment. Blank forms may be duplicated for personal use.

Children’s Hospital of Illinois

Children’s Hospital of Illinois is driven by a Mission to provide integrated, comprehensive, pediatric health care to children from birth to 18 years of age in Illinois. As a premier children’s health care facility, we address the spiritual, emotional and physical needs of our pediatric patients based on three principles:

• Children are unique and have special needs
• A child’s illness affects the entire family
• Childhood illness interferes with normal childhood growth and development

Our goal is to ensure Children’s Hospital of Illinois meets not only the needs of our patients, but their families as well. In an effort to do this and provide your child the best care, we have adopted the following consent form for your convenience.
Consent for Medical Treatment of a Minor Child

I, ____________________________________________________________________________  
(parent(s) or guardian(s) name(s)) 
________________________________________________________________________________
(street address, city, state) 
give permission to  _______________________________________________________________________________  
(name(s)) 
________________________________________________________________________________
(street address, city, state) 
to take temporary care of the following child,  ____________________________________________________________  
(name and date of birth) 

This power of temporary authority begins on ____________________________________________________________  
(date) 
and remains effective through  ____________________________________________________________ .  
(date – this authority can remain effective for up to 1 year) 

The above-named caretaker(s) have the following powers: 
1. The power to seek appropriate medical treatment or attention on behalf of the child as required by the circumstances, including but not limited to medical doctor or hospital visits 
2. The power to receive medical information 
3. The power to authorize medical treatment or medical procedures in an emergent situation 
4. The power to ____________________________________________________________________________ 

Date and time: ____________________________________________________________________________ 
Signature: ____________________________________________________________________________  
(parent(s) or legal guardian(s)) 

Printed name: ____________________________________________________________________________  
(parent(s) or legal guardian(s)) 

Witness: ____________________________________________________________________________  
(office personnel or notary) 

Information Request 
Family doctor: ____________________________________________________________  

Phone: ____________________________________________________________________________  

Medical Insurance 
Insurance carrier: ____________________________________________________________  

Identification/policy number: ____________________________________________________________  

Member’s name: ____________________________________________________________  

Account number: ____________________________________________________________  

Medical History 
Allergies (including medication allergies): ____________________________________________________________  

Chronic or existing diseases or medical problems (e.g. asthma, diabetes, epilepsy):  ____________________________________________________________  

Medicines your child is currently taking: ____________________________________________________________  

Date your child last received Tetanus injection or booster: ____________________________________________________________  

In an emergency, parent(s) or guardian(s) may be reached at: 
Name: ____________________________________________________________  

Phone: ____________________________________________________________  

Address: ____________________________________________________________