



St Anthony's
Memorial Hospital
 Effingham, Illinois

APPOINTMENT AND CONSENT FOR MEDICAL TREATMENT

Please complete **ONE** form for each minor child (under age 18) and leave in the possession of adult responsible for minor's care. Please **print or type**. Thank you.

I (We) will be out of town or otherwise unavailable to consent from _____ to _____.
MY CHILD:

_____/_____/_____
 (Full Legal Name) (Age) Birthdate

 (Home Address) (City) (State) (Home Telephone Number)

 (Medical History)

 (Current Medications)

 (Allergies) (Date Last Tetanus Shot)

My child will be staying with the following person(s) whom I appoint as short term guardian(s):

 (Name) (Relationship)

 (Home address) (City) (State)

 (Home Telephone Number)

During this period, with this document, I hereby authorize a licensed medical care institution and physicians to render emergency medical care as may be required. I also authorize the person named above to consent to any medical treatment deemed necessary by our physician or the Emergency Service physician.

Our family physician (or pediatrician) is:

 (Physician's name) (Telephone Number)

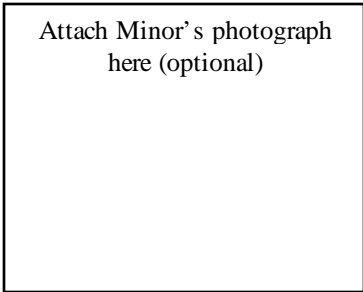
 (City) (State)

Please notify said physician.

 Mother's/Father's Signature Date

 Legal Guardian's Signature Date

 Witness's Signature Date



This appointment will expire on the return date above or 60 days after date of signature whichever is later.