**Montclair State University**
**Ben Samuels Children's Center**

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## Consent for Medical / Surgical Care / Emergency Treatment / And Child's Medical Information

In presenting my son/daughter for diagnosis and treatment

Name ______________________________________________ for _________________________________________
Mother Father Legal Guardian Son Daughter

_______ years of age hereby voluntarily consent to the rendering of such care including diagnostic procedures, surgical and medical treatment and blood transfusions by authorized members of the hospital staff 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.

We/I hereby give my consent to ________Montclair State University Ben Samuels Children's Center__________________
(Name of person/agency)

Who will be caring for our (my) child _____________________________________________________________
(Name of child)
for the period _______________ to _________________ to arrange for routine or emergency medical / surgical / dental care and treatment necessary to preserve the health of our (my) child.

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period.

Name: ___________________________________
Address: _________________________________
_________________________________________
Telephone #. : ____________________________
Name of Health Insurance Carrier:
_________________________________________
_________________________________________
Group No. : _______________________________
Agreement No. : ___________________________

Family Physician: ______________________________
Pediatrician: __________________________________
Surgeon: ______________________________________
Orthopedist: ___________________________________
Child's Allergies (if any):
_____________________________________________
Date of last tetanus booster: ____________________
Medicines child is taking:
_____________________________________________
_____________________________________________

Signature: ___________________________________ Date: ___________________________________

Witness: ____________________________________ Date: ___________________________________

IN CASE OF EMERGENCY I CAN BE REACHED AT: ___________________________________
___________________________________