Scheurer Healthcare Network
170 N. Caseville Road
Pigeon, Michigan 48755

Phone: (989) 453-3223

04/2011

SCHEURER HEALTHCARE NETWORK

Consent for Medical Treatment of a Minor Child or Dependent Adult

People You Trust,
Caring For People You Love

Dad, Mom or Legal Guardian

Before you leave your child or dependent adult with another caregiver (such as a family member or babysitter), and may not be able to be reached, please complete the following information.

If your child/dependent adult's caregiver presents a completed form, they will be able to obtain medical treatment for your child/ dependent adult in your absence.

Our staff will still attempt to call you or the second contact person if a phone number is available.

Please instruct your child/dependent adult's caregiver to keep a completed form with them at all times, so if your child/dependent adult needs emergency treatment, they can present it at the time the child/dependent adult arrives.

A **separate** form is needed for each child/dependent adult.

Consent for Medical Treatment of a Minor Child or Dependent Adult

I, _____,
Print name of Parent or Legal Guardian

am the parent or legal guardian of

_____
Print name of the Child/Dependent Adult

who was born on ____/____/____, and lives at

_____
Street Address

_____ _____ _____.
City State Zip Code

I give permission for

_____,
Print the name of Caregiver

who is over 18 years of age and lives at

_____
Street Address

_____ _____ _____
City State Zip Code

to consent for medical treatment
for the child/dependent adult named above.

_____
Signature of Parent or Legal Guardian

Date: ____/____/____

Time period that permission is given for:
Not to exceed 6 months*

From: ____/____/____ to ____/____/____

*This form is only valid for a period of six (6) months unless the parent or guardian is serving in the armed forces of the United States and is deployed to a foreign nation, and the power of attorney provides, this form may be in effect until the thirty-first day after the end of deployment (MCL 700.5103)

SHN Staff: If time period is left blank or exceeds 6 months (and the parent/guardian is not deployed), write in the date you receive it and the six month ending date and initial the form.

Medical Information

Family Physician: _____
Telephone: ( ) _____ - _____

Allergies: ☐ None

_____

_____

Current Medications: ☐ None

_____

_____

Medical History:

_____

_____

_____

Immunizations up-to-date? ☐ Yes ☐ No

Comments: _____

Last Tetanus or Booster: ____/____/____

Parents or Guardian can be reached at:

Name: _____

Address: _____

_____

Telephone: ( ) _____-_____

Second Contact Person:

Name: _____

Address: _____

_____

Telephone: ( ) _____-_____

Insurance Information

Ins. Name: _____

Contract #: _____

Ins. Group #: _____

Subscriber Name: _____

Please attach a copy of the insurance card if available.