JERSEY COMMUNITY HOSPITAL

400 Maple Summit Road
Jerseyville, IL 62052

PERMISSION TO TREAT

I, _____, residing at _____, do hereby state that I am the natural parent and/or legal guardian of _____, a minor, whose date of birth is _____, and who resides at _____.

I hereby authorize the bearer of this letter:

_____

_____

_____

To consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to th said minor child, under the general or special supervision, and on the advice of any licensed physician or surgeon, when such medical or surgical treatment is necessary, and I will be responsible for any costs of same. I also certify said minor child is covered under the _____ insurance plan, and the name of the policy holder of said plan is _____.

Child's physician: _____ Phone: _____
Preference of Surgeon: _____ Phone: _____
Preference of Hospital: _____
Preference of Dental Surgeon: _____ Phone: _____
Child's allergies: _____
Medication child is taking: _____
Date of child's last tetanus shot: _____

I certify that the above information is true and correct.

_____ _____
Signature of Natural Parent and/or Legal Guardian Date

(This form is good for two years)

mme: 5/92, 3/97, 6/00, 8//14