
Family Physician

Telephone

Family Dentist

Telephone

Primary Insurer

Name of Insurance Company

Identification Number

Group Number (If Any)

Signature (Insured Parent or Guardian)

Additional Insurance

Name of Insurance Company

Identification Number

Group Number (If Any)

Signature (Insured Parent or Guardian)

In addition to providing the information above, please attach a photocopy of all insurance cards.

Parent or guardian can be located at the following address(es) and phone number(s):

*This is a legal document.
Take it with you and give it to the physician, dentist or hospital representative so that necessary treatment can be given to a child whose parents or guardians cannot be contacted for permission.*

Riverview

MEDICAL CENTER

410 Dewey Street, P.O. Box 8080
Wisconsin Rapids, WI 54495-8080

(715) 423-6060

www.riverviewmedical.org

Consent for Medical Treatment of a Minor Child



Riverview

MEDICAL CENTER

Please complete a separate form for each minor child.

I, (We) _____ and _____ of _____,
(name) (name) (city)

_____, _____, do hereby state that I am (we are) the parent(s) or legal guardian(s) of :
(county) (state)

_____, minor, age _____, born _____, who resides with
(name) (age) (birthdate)

me (us) at _____.
(address)

I (We) authorize _____, an adult, who resides at _____ in the city of
_____, county of _____, state of _____ to act in my (our)

behalf in authorizing medical, dental, surgical care and hospitalization for the above named minor for the period of time (not to exceed one year) beginning:

_____ and ending _____
(month) (day) (year) (month) (day) (year)

I (We) do hereby indemnify and hold harmless the physicians, dentists, hospital and other persons who act in reliance upon this authorization.

(signature of parent or guardian) (signature of parent or guardian)

(signature of witness - anyone over age 18) (date signed)

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as medical, dental, surgical care or hospitalization may be required.

Allergies: _____ Date of Last Tetanus Booster: _____

Chronic Diseases or Medical Problems/Needs: _____

Current Medications: _____

(Over)