

## Medical Information

**Chronic or Existing Medical Conditions (i.e. asthma, epilepsy, diabetes)**

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**Recent Shots and Vaccines**

Tetanus/DPT & Date \_\_\_\_\_

Other & Date \_\_\_\_\_

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**Current Daily Medications**

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**Known Allergies**  
Circle all that apply:

<p><u>Medications</u></p> <p>Anesthetics _____</p> <p>Antibiotics _____</p> <p>Aspirin _____</p> <p>Codeine _____</p> <p>Cortisone _____</p> <p>Demerol _____</p> <p>X-ray Dyes _____</p> <p>Morphine _____</p> <p>Xylocaine/Novacaine _____</p> <p>Tetanus Toxoid _____</p> <p>Other _____</p>	<p><u>Food/Other</u></p> <p>Milk _____</p> <p>Eggs _____</p> <p>Wheat _____</p> <p>Soy _____</p> <p>Peanuts _____</p> <p>Tree Nuts _____</p> <p>Fish _____</p> <p>Shellfish _____</p> <p>Insect Stings _____</p> <p>Latex _____</p> <p>Other _____</p>
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**For an Emergency,  
Dial 9-1-1**



**Putnam County Hospital**

1542 S. Bloomington Street  
Greencastle, Indiana 46135

Phone: (765) 653-5121  
[www.pchosp.org](http://www.pchosp.org)

# Parental Consent and Medical Release Form



**Putnam County Hospital**

# Putnam County Hospital

## Consent of Treatment



### Protect your child while you're away.

You know your child is in good hands when with your caregiver—but what if a medical emergency occurs?

By completing this form, you are granting Putnam County Hospital permission to provide medical assistance, if it becomes necessary, when your child is in the care of someone else.

Please be thorough in providing all of the requested information. You must complete a separate form for each child. Then, give copies of the form to every person who is responsible for caring for your child.

If your child is under the care of a minor (under 18 years old), the minor's parent or guardian must have authorization to give consent for medical treatment.

*Please note: Physicians have discretion regarding certain medical procedures, and may require direct parental consent before performing them.*

*Not all facilities will accept this form.*

Extra copies of this form can be accessed by visiting [www.pchosp.org](http://www.pchosp.org) and clicking on Forms under Services

Child's Name \_\_\_\_\_ Child's Date of Birth \_\_\_\_\_

TO WHOM IT MAY CONCERN (Please print clearly)

I (we) \_\_\_\_\_ and \_\_\_\_\_  
Name Name

of \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
City County State

grant permission for Dr. \_\_\_\_\_ and/or the Putnam County Hospital Emergency Department

and/or Immediate Care Centers to provide medical care as deemed necessary to the above dependent while being cared for

by \_\_\_\_\_, effective from \_\_\_\_\_ through \_\_\_\_\_  
Name Date Date

If the person caring for my child is a minor, I grant permission for the minor's parent/guardian, \_\_\_\_\_, to request and authorize in writing, or as otherwise requested  
Name

by Putnam County Hospital, any and all examinations, medical treatment and/or procedures to or for the above named minor, either on or off the premises of Putnam County Hospital, as may be deemed advisable or appropriate by any physician or surgeon able to practice medicine in the State of Indiana.

Emergency Cell Phone Number for Parent/Guardian \_\_\_\_\_

#### SIGNATURES (must be completed)

\_\_\_\_\_  
Parent/Guardian and Date

\_\_\_\_\_  
Parent/Guardian and Date

\_\_\_\_\_  
Address and Zip Code

\_\_\_\_\_  
Witness and Date

#### FAMILY PHYSICIAN

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone Number

#### INSURANCE COMPANY INFORMATION

\_\_\_\_\_  
Insurance Company

\_\_\_\_\_  
Company Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Company Phone Number

\_\_\_\_\_  
Policy Holder's Name and Date of Birth

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Group/Account Number

\_\_\_\_\_  
Policy Holder's Employer