# Consent to Emergency Care

FORM 125 - R170706

**Patient Name** _____ **Date of Birth** _____

**CONSENT GIVEN TO: Person/Agency Name** _____

**CONSENT TIME PERIOD: Beginning Date** _____ **Ending Date** _____

CONTACT INFO

**Address** _____

**City** _____ **State** ____ **Zip** _____

**Primary Phone** _____

**Secondary Phone** _____

DOCTOR INFO

**Family Physician** _____

**Pediatrician** _____

**Surgeon** _____

**Orthopedist** _____

MEDICAL INFO

**Allergies** _____

_____

**Medicines** _____

_____

_____

**Date of last tetanus booster** _____

INSURANCE INFO

**Health Insurance Carrier** _____

**Group Number** _____

**Policy Number** _____

**Dental Insurance Carrier** _____

**Group Number** _____

**Policy Number** _____

IN PRESENTING MY SON/DAUGHTER FOR DIAGNOSIS AND TREATMENT, I HEREBY VOLUNTARILY CONSENT TO THE RENDERING OF SUCH CARE, INCLUDING DIAGNOSTIC PROCEDURES, SURGICAL AND MEDICAL TREATMENT, AND BLOOD TRANSFUSIONS BY AUTHORIZED MEMBERS OF THE CLINIC 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 MY CHILD'S CONDITION.

I HEREBY GIVE CONSENT TO THE PERSON/AGENCY LISTED ABOVE WHO WILL BE CARING FOR MY CHILD FOR THE PERIOD OF TIME INDICATED, TO ARRANGE FOR ROUTINE OR EMERGENCY MEDICAL/DENTAL CARE AND TREATMENT NECESSARY TO PRESERVE THE HEALTH OF MY CHILD.

I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL REASONABLE CHARGES IN CONNECTION WITH CARE AND TREATMENT RENDERED DURING THIS PERIOD.

I HAVE READ THIS FORM AND CERTIFY THAT I UNDERSTAND ITS CONTENTS.

**Signed by** _____ **Date** _____

**Print Name** _____ **Relationship to Patient** _____

**In case of emergency I can be reached at** _____

Salem Pediatric Clinic

2478 13th Street SE
Salem, Oregon 97302
503-362-2481 · Phone
503-371-7803 · Fax
SalemPediatricClinic.com