Family or Child's Provider

_____

Phone: _____

Medical Insurance Carrier

_____

ID# _____

Member Name _____

Benefit Code _____

Account # _____

Medical History

Allerigies and medication allergies

_____

_____

_____

Chronic/existing disease (e.g. diabetes, epilepsy)

_____

_____

_____

Medications your child is taking now

_____

_____

_____

Emergency Notification

In the event of serious injury or illness, the parent or parents of the minor child may be reached as follows:

_____

_____

_____

_____

_____

_____

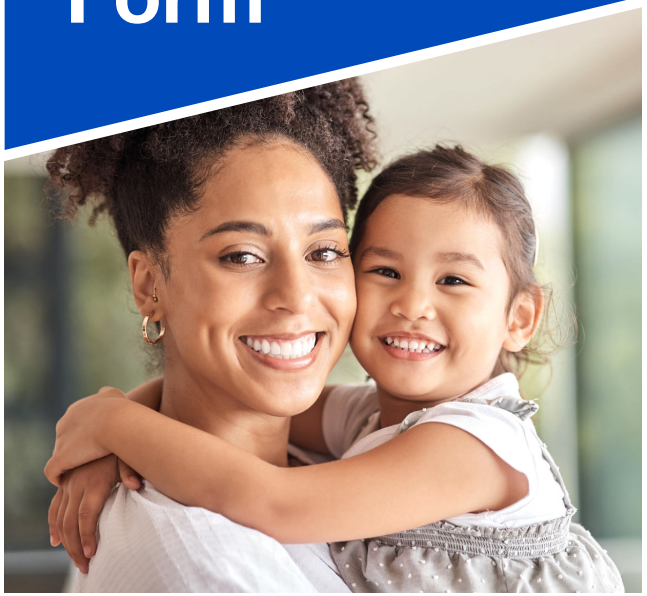
_____

_____

NORTON KING'S DAUGHTERS' HEALTH

1373 E. State Road 62 • Madison, IN 47250
(812) 801-0800

Medical Consent Form



NORTON KING'S DAUGHTERS' HEALTH

You have probably made plans for someone to care for your minor child or children when not in your care. This could be care from a grandparent, daycare provider, aunt or uncle, or a friend or neighbor.

We are providing a consent form and medical data questionaire which will be valuable should your child become ill or injured while you are away.

This form may also be used if your minor child is leaving home, such as going camping or traveling with a friend's family. This information will be helpful - and may be required - to give your child the prompt medical care he or she may need.

If care is needed, the individual(s) may bring this information to the hospital, physician's office or urgent care facility. This consent lets the hospital staff and or providers know that you have given permission for your minor child's care provider to make decisions regarding medical care of your child.

Consent for medical treatment of a minor child

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

of _____ (city), _____ (county), _____ (state), do

hereby state that I (we are) the parent(s) or legal guardian(s) of

_____ (name), a minor, age _____ (age), born _____ (date of birth).

I (We) authorize _____ (name of caregiver), an adult, who resides

at _____ in the city of

_____, county of _____, state of

_____ to consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to the above-named minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the state(s) of

_____.

Dated this _____ day of _____, 20 _____.

_____ (signature of parent or guardian)

_____ Notorization of Signatures to Affidavit, subscribed and sworn to me, Notary Public.