PEDIATRIC ASSOCIATES OF BROCKTON
(508) 584-1234

Date:_____

Pediatric Associates Consent for Treatment

If at any time my child, _____ become seriously ill or injured and I cannot be reached, please contact the following people:

Nearest Relative: _____ Tel #: _____

Neighbor: _____ Tel #: _____

In the event of an emergency, and I cannot be contacted, I give permission to hospitalize my child and place him or her with a competent physician for any treatment that is essential to the physical well being of my child.

Mother Signature: _____

Father Signature: _____

Legal Guardian Signature: _____

Primary Care Physicians Name: _____

Do you have insurance? YES NO

Name of Insurance: _____

Subscriber Name: _____ Social Security #: _____

Insurance ID Number: _____ Member #: _____

Mass Health Card #: _____

Seq: _____ Mass Health Number: _____

Over for child's medical history

Child's Name:_____ DOB:_____

Height:_____ Weight:_____

Address:_____

Pediatrician:_____ Phone #:_____

Hospital:_____ Phone#:_____

Child's Allergies:_____

_____

Medications child is current taking:_____

_____

Date of Last Tetanus:_____

Surgeries/Date:_____

_____

_____

Other Pertinent Information:_____

_____

_____

I certify that the above information is true to the best of my knowledge on this _____ Day of _____, 20__.

Parent/Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____

PF005 Permission Med Tx/Emergency Info.doc
md/15