Consent for Emergency Medical Treatment at Mason District Hospital

Mason District Hospital
Superior Healthcare. Close To Home.

Dates the minor will be left in another person's care: _____

Minor's Name: _____

Minor's Date of Birth: _____

Person Caring for the Minor: _____

Minor's Allergies: _____

Medical History of the Minor: _____

Date of Last Tetanus Shot: _____

Home Address: _____

_____

Telephone Number: _____

Family Physician or Pediatrician: _____

Location and Telephone Number of Family Physician or Pediatrician:

_____

Insurance Company: _____

Insurance Policy Number: _____

During this period, with this document, I hereby authorize the Emergency Department physician and staff at Mason District Hospital to give the emergency medical care required.

Legal Guardian: _____ Date: _____

Witness: _____ Date: _____