HARRINGTON MEMORIAL HOSPITAL
SOUTHBRIDGE, MASSACHUSETTS

GENERAL MEDICAL CONSENT FOR TREATMENT OF MINORS IN THE EMERGENCY ROOM

In case of accident or illness, I/we hereby authorize the physician and personnel at Harrington Memorial Hospital to examine and administer such treatment, medication and procedure(s) found to be necessary for the diagnosis and treatment of my/our son/daughter.

Name: ______________________________ Date of Birth: ________________

Exceptions: (If none, so state): ______________________________

Date(s) this consent is in effect: ________________ through: ________________

The explanation of the medical problem will be made to the patient and/or the person who accompanies my/our offspring to the hospital. One or both of them shall sign the informed consent.

PARENT OR GUARDIAN MUST SIGN HERE:

Date: ____________ Signed: ______________________________
(Relationship)

Date: ____________ Signed: ______________________________
(Relationship)

Witness: ______________________________

Patient's family physician: ______________________________

Allergies: ______________________________

Date of last tetanus immunization: ______________________________

Pertinent medical conditions: ______________________________

Medications presently being taken: ______________________________

____

Medical insurance/person responsible for payment: ______________________________

____

Policy #: ______________________________

A photostat copy of this form is to be attached to each emergency record. This consent is to be kept in the permanent file if used. It is only valid for a **one month** interval.