cooperative children's center

4759 15th Ave NE, Seattle, WA 98105

Phone 206.522.5388/ Fax 206.527.8399/Email program_supervisor@coopchild.org

Consent to Medical Care and Treatment of Minor Children

I, _____ the parent/legal guardian of _____, authorize and consent for medical and emergency care to be given by the Cooperative Children's Center staff and aid care personnel until transported to a licensed medical facility. I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment.

Signature of parent/guardian_____

Address_____City_____ Zip _____

Home Phone _____ Work Phone _____

Date _____ Witness _____

Witness _____

*This consent form has been approved by the Seattle Area Hospital Council.

Health information

Child's birth date: _____

Allergies (including any known drug reactions) _____

_____

Chronic illnesses_____

Regular medications _____

Child's physician _____Phone number _____

Physician's address_____

*If you do not have a doctor, please list the nearest hospital that you would use.

Child's dentist_____ Phone _____

Dentists address _____

Insurance coverage_____ Group # _____ _Member #_____

Other pertinent data _____