



Apply patient ID sticker or write patient name and birthdate.

UNIVERSITY OF IOWA HEALTH CARE MEDICAL CENTER DOWNTOWN IOWA CITY, IOWA

PERMISSION FORM FOR MEDICAL CARE IN PARENTAL ABSENCE

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EMERGENCY CARE UNIT - (319) 339-3600 (This form must be presented upon admission for treatment.)

In the event that my child/children (listed below) may require medical and/or surgical care while I am out of the city or unable to be reached, I hereby give my consent to medical and/or surgical treatment to _____ Hospital and Dr. _____, or his/her designee to provide this care, upon the authorization of:

Name of temporary guardian: _____

Address: _____

Telephone: _____

This consent will be in effect beginning _____ and ending _____

Table with 6 columns: Child's name, Birth Date, Age, Present Medication, Known Allergies, Date of Last Tetanus

Short history of medical problems: (if more room is required, please use back.)

Religious Preference

Insurance

Father's Signature

Father's Social Security Number

Mother's Signature

Mother's Social Security Number

Witness

Date Time

