



PATIENT CONTACT INFORMATION

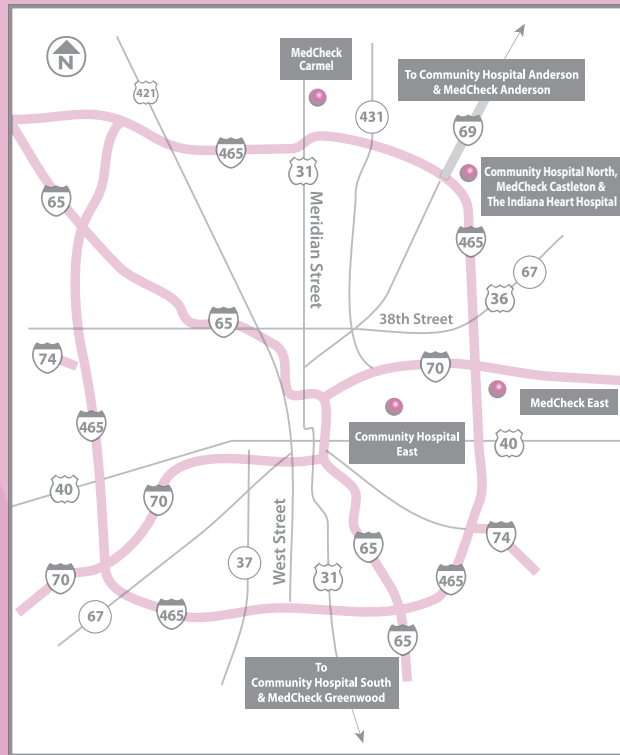
Mother () _____ Home
 () _____ Work
 () _____ Cell
 email: _____

Father () _____ Home
 () _____ Work
 () _____ Cell
 email: _____

Legal Guardian () _____ Home
 () _____ Work
 () _____ Cell
 email: _____

If unable to contact the parent(s) or legal guardian, please contact:

Name _____
 Relationship _____
 Phone/Cell _____



Ranked among the top 20 integrated health care networks in the nation, Community Health Network includes Community Hospital Anderson, East, North and South; The Indiana Heart Hospital, a dedicated heart hospital; MedCheck urgent care centers; Indiana Surgery Centers, more than 50 primary care physician practices; home health services; nursing homes; and other health care facilities in central Indiana. Community Health Network makes a difference by getting you well and back to your life.

Community Hospital East
 1500 N. Ritter Avenue
 Indianapolis, IN 46219

Community Hospital North
 7150 Clearvista Drive
 Indianapolis, IN 46256

Community Hospital South
 1402 E. County Line Rd. South
 Indianapolis, IN 46227
 10891 0505 ESI # 4931

Parent Consent Form



WHEN YOU GO AWAY, PROTECT YOUR CHILDREN

Although you probably have someone to care for your children when you're going away, it's a good idea to make sure their healthcare needs are taken care of, too.

By completing this form and providing all the proper signatures, you are granting permission for Community Hospitals of Indiana, Inc. and our medical staff to provide medical assistance to your child when that child is under someone else's care.

You must complete a separate form for each child. Then, provide copies of the form(s) to every person who is responsible for the care of your child. Also, remember to send along a form when your child is going away, whether it's to travel, go to camp, or other circumstances.

PLEASE NOTE: The physician has discretion regarding certain medical procedures, and may require direct parental consent before performing these procedures.

CONSENT FOR TREATMENT

Name of Child: _____

Date of Birth: _____

To Whom It May Concern (please print clearly)

I (We) _____
Parent/Guardian

of _____, _____, _____
City County State

I grant permission for Community Hospitals of Indiana, Inc. and any of its entities to provide medical care as deemed necessary to the above named dependent while being cared for by

_____ name

effective from _____ date through _____ date

Family Physician
Name: _____

Insurance Company
Name: _____

I.D. (policy) number: _____

Address: _____

Phone number: _____

Signature (must be completed)

_____ Parent/Guardian Date

MEDICAL INFORMATION

Any chronic or existing medical conditions (i.e., hemophilia, epilepsy, diabetes)

Blood Type (if known)

- O
 A
 B
 AB

- Positive
 Negative

Know Allergies

- Negative
 Anesthetics
 Antibiotics

- _____

 Aspirin
 Codeine
 Cortisone
 Demerol
 Insect Stings
 I.V.P. Dyes
 Morphine
 Novacaine
 Tetanus Toxoid
 Other _____

Recent Shots and Vaccines

Tetanus/Date: _____

DPT/Date: _____

Other/Date: _____

Current Daily Medications (if any)

