



THE FINLEY HOSPITAL

IOWA HEALTH SYSTEM

TO: PARENTS OF MINOR CHILDREN (Under the Age of 18)

In order for children to receive faster medical care when they are sick or injured during their parent's absence, The Finley Hospital offers a "Permission to Treat Minor Children" consent form.

State law prohibits hospitals from treating minor children, except in life-threatening situations, without first obtaining permission from the child's parents or legal guardian. This law is designed to protect all parties involved, but it can result in delays while hospital personnel attempt to locate a child's parent.

NOTE: The form is not necessary in life threatening situations. Please be assured that treatment will be given if delay would affect the child's welfare.

PLEASE FILL OUT THE FORM BELOW COMPLETELY... especially the dates for which it is effective (usually until the child is age 18) and sign the form. *(The form is not valid without effective dates and a signature.)*

It is necessary to complete one card for each child in the family. Additional forms are available in the Finley Emergency/Trauma Center. **Completed cards should be cut at the dotted line and returned to the Finley Emergency/Trauma Center.**

We are happy to provide this opportunity to make emergency care possible for your child at all times. If you have and questions, please call the Finley Emergency/Trauma Center at 563.589.2460.



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350 N. Grandview Dubuque, IA 52001

Child's Name: _____
(Last) (First) (Initial)

Age: _____ Birthdate: _____

Church: _____

Insurance: _____

Child's Physician: _____

Family Physician (if not the same): _____

Your choice of specialists if needed such as Surgeon, Orthopaedic Surgeon, etc.: _____

Previous surgery or minor injury: _____

List and allergies the child is known to have: _____

Date of last tetanus shot: _____

PERMISSION TO TREAT MINOR CHILDREN

Date(s) Effective: _____, 20__ to _____, 20__
Medication child is taking: _____

Parent's Name: _____
Address: _____

Home Phone No.

Work Phone No.

Responsible adult in parent's absence:

Home Phone No.

Work Phone No.

This is to certify that I, the undersigned, consent to and authorize the performance of all treatment, operations, and the administration of anesthetics which, in the judgment of the attending physician, may be deemed necessary.

Signature of Parent or Legal Guardian

Date