



# Parental Consent: Emergency Release

## Lake Forest Hospital

660 N. Westmoreland Road  
Lake Forest, Illinois 60045-1696  
(847) 234-5600

At Lake Forest Hospital, we know what a great responsibility it is to raise children. We want to help you care for your children and prepare for the unexpected. Because we know it's important for your family's well being—and your family's well being—we are providing this emergency consent form. It is designed to make sure your children receive the medical attention they need when you are out of town or otherwise unavailable.

Although emergency care always will be administered in the case of life-and limb-threatening illnesses or injuries, your permission is needed before other emergency treatment can be provided. To ensure there is no delay in treating your child when you are unavailable, fill out a copy of this form for each child, and leave it where it can be found easily by the person you have selected as "temporary guardian" (teacher, neighbor or babysitter). In the event of an emergency, the guardian should bring the form to the emergency room. This will allow us to provide prompt treatment even without your presence.

**FILL OUT A COPY OF THIS FORM FOR EACH CHILD**

\_\_\_\_\_  
Father

\_\_\_\_\_  
Mother

\_\_\_\_\_  
The parents of (name of minor child)

\_\_\_\_\_  
Have temporarily given the guardianship of said child to

The named guardians have full authority to sign and approve any emergency medical care that the above-mentioned child may require during our absence.

\_\_\_\_\_  
SIGNATURE OF FATHER

\_\_\_\_\_  
SIGNATURE OF MOTHER

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
**This release is effective from (date) to (date)**

**Parents' address, should notification be necessary because of serious illness, is as follows:**

\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

### IMPORTANT MEDICAL INFORMATION FOR THE CHILD

Allergies: \_\_\_\_\_

Known medical illness: \_\_\_\_\_

Medications currently being taken: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Name and phone number of family physician/dentist  
\_\_\_\_\_

Name of insurance: \_\_\_\_\_

Name of policy holder: \_\_\_\_\_

Group number: \_\_\_\_\_