



Parental Consent for Medical Treatment of a Minor Child

To avoid possible delay in providing medical treatment in the event your child becomes ill or injured while at EIRMC-BHC, Teton Peaks Residential Treatment, your signature on this form assures that your minor child will receive prompt, personalized attention if you or a guardian are not immediately available. If care or treatment is needed at a facility other than EIRMC, hospital staff will present this form and share your child's health information, as appropriate, with a physician or health care provider at the treating facility.

Child's name _____ Child's Birth Date _____

Home Address _____
(street) (city, state, zip)

Parent's/Guardian's Name _____ day ph _____ evening ph _____

Parent's/Guardian's Name _____ day ph _____ evening ph _____

Alternate Home Address _____
(street) (city, state, zip)

Alternate phone (if not at work or home) _____

I (we) the parent(s) or guardian(s) named above authorize any necessary examination, anesthetic, blood transfusion, medical diagnosis, etc. and/or hospital care to be rendered to the above-named minor child under the general or special supervision and on the advice of any licensed physician. I (we) agree to pay for all services provided to my child in my absence.

My child is currently receiving care at Teton Peaks Residential Treatment Center, EIRMC-BHC. I authorize the release of my child's health information contained in the medical record at Teton Peaks, if needed, to provide my child with appropriate care at an alternate facility.

Signatures:

Parent or Guardian _____ Date _____

Parent or Guardian _____ Date _____

Teton Peaks Staff Witness _____ Date _____

White copy in the chart – Yellow copy to Recreation Therapy Department

