CONSENT FOR MEDICAL / SURGICAL CARE / EMERGENCY TREATMENT AND CHILD'S MEDICAL INFORMATION

In presenting my son / daughter for diagnosis and treatment

Parent's Name: _____ for _____
◯ Mother ◯ Father ◯ Legal Guardian PRINT CHILD'S FULL NAME ◯ Son ◯ Daughter

of _____ years of age; hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment, and blood transfusions, by authorized members of the hospital staff or their designees, as may in their professional judgement be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on child's condition.

I have read this form and I certify that I understand its contents.

We / I hereby give my consent to **Kyle Hughes or Chaperones of Team RUSH**
(Name of Person, Agency)

who will be caring for our (my) child _____
(Name of Child)

for the period **_____ to _____** to arrange for routine or emergency medical / surgical / dental care and treatment necessary to preserve the health of our (my) child.

We / I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period.

Name: _____ Family Physician: _____

Address: _____ Pediatrician: _____

_____ Surgeon: _____

Telephone No. _____ Orthopedist: _____

Name of Health Insurance Carrier: Child's Allergies, if any:

_____ _____

_____ Date of last tetanus booster: _____

Group No. _____ Medicines Child is taking:

Agreement No. _____ _____

Signature: _____ _____
Mother, Father or Legal Guardian Date

Witness: _____ _____
Mother, Father or Legal Guardian Date

IN CASE OF EMERGENCY I CAN BE REACHED AT _____

State of Michigan
County of _____

On the _____ day of _____ 20___, personally appeared before me, _____

whose identity was proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument.

Signed, sealed and acknowledged/delivered in the presence of: _____
Notary Seal