



# Medical Treatment Consent Form

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Did you know that in your absence, no one caring for  
your children can authorize their medical care  
without your written permission?

If you leave your child with a babysitter, family member or other caregiver while you are  
working or traveling, complete this form, have it witnessed and leave it with your caregiver.  
This will ensure that in an emergency, your child will receive prompt, necessary medical care  
even if you are not there to give consent.

## Consent For Medical Treatment

In case of emergency, I authorize:

(Full Name) \_\_\_\_\_ of

(Full Address) \_\_\_\_\_ Tel: \_\_\_\_\_

to give consent during my absence for my child(ren) listed below to be hospitalized, have surgery  
or receive other necessary healthcare.

## Child's Information (See page 2 for additional children covered by this Consent)

Child's full name \_\_\_\_\_ Date of birth \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Child's Physician \_\_\_\_\_ Tel: \_\_\_\_\_

Important medical history (chronic conditions, allergies, reactions, etc.)

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

## Parent(s)/Guardian(s) Information

Name \_\_\_\_\_ Tel: \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witnessed by: (Print Full Name) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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### Other Children Covered by this Consent:

#### Child 2 Information

Child's full name \_\_\_\_\_ Date of birth \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Child's Physician \_\_\_\_\_ Tel: \_\_\_\_\_

Important medical history (chronic conditions, allergies, reactions, etc.)

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

#### Child 3 Information

Child's full name \_\_\_\_\_ Date of birth \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Child's Physician \_\_\_\_\_ Tel: \_\_\_\_\_

Important medical history (chronic conditions, allergies, reactions, etc.)

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

#### Child 4 Information

Child's full name \_\_\_\_\_ Date of birth \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Child's Physician \_\_\_\_\_ Tel: \_\_\_\_\_

Important medical history (chronic conditions, allergies, reactions, etc.)

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