Rainbow Years Learning Ministry
7235 W 100 N
Shipshewana, IN 46565
1.260.768.7153
www.rainbowyears.org

Enriching the Lives of Children Through Dependable Christian Care

CONSENT TO TREAT MINOR CHILDREN

I, _____, the parent or legal guardian of_____, born on _____, do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said child is under the care of **Rainbow Years Learning Ministry of 7235 W 100 N, Shipshewana, IN 46565** and I am not reasonably available by telephone to give consent.

This authorization is effective from _____ (date) until _____ (date).

_____ _____
Signature of Parent or Legal Guardian **Date**

_____ _____
Witness Signature Witness Name (please print)

This consent form will be taken with the child to the hospital or physician's office when thechild is taken for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address_____

Parent/Guardian Telephone: _____ Parent/Guardian Telephone: _____

Last Tetanus: _____

Allergies to drugs or foods: _____

Special Medications, Blood Type or Pertinent Information: _____

_____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy #_____

Preferred Hospital: _____