
Names of children covered by this authorization:

1) _____
First Middle Last

Birthday Blood Type

List any allergies or current medications:

Has this child ever been a patient at St. Francis Hospital? Yes No

2) _____
First Middle Last

Birthday Blood Type

List any allergies or current medications:

Has this child ever been a patient at St. Francis Hospital? Yes No

3) _____
First Middle Last

Birthday Blood Type

List any allergies or current medications:

Has this child ever been a patient at St. Francis Hospital? Yes No

St. Francis Emergency Services

St. Francis Emergency Rooms feature

- 24 hour care
- Full-time emergency physicians and nursing staff
- The latest technologies in emergency care.

Emergency rooms are located at the following campuses:

Beech Grove Campus
(317) 783-8261

Indianapolis Campus
(317) 865-5261

St. Francis PromptCare and PromptMed are perfect for minor emergencies. These urgent care centers are located at the following campuses:

PromptCare
Indianapolis Campus
(317) 865-5261

PromptMed
 Mooresville Campus
(317) 834-9400

Medical Care Authorization

Emergencies Can Happen at Anytime



Authorize Medical Care for Your Children in Your Absence

⚔ ST. FRANCIS MEDICAL GROUP

This form serves as an authorization by parents for another to consent to their child's hospitalization, surgery or special medical procedures during their absence.

(Authorization is for 60 days maximum.)

We hereby appoint

Name: _____

Address: _____

Street

City

State

Zip

Phone: _____

As the person who, in my/our absence from _____ (city), Indiana, shall be authorized to consent for all medical and/or surgical treatment and/or special procedures (including by way of illustration and not limitation, administration of anesthesia, blood transfusions, diagnostic tests, etc.) which may be required during my/our absence. Without in any manner limiting the foregoing appointment and authorization, if circumstances permit, I would like to have our physician consulted in connection with such medical and/or surgical treatment and/or special procedures.

Child's Mother's Name: _____

Child's Father's Name: _____

Address: _____

Street

City

State

Zip

Phone: _____

St. Francis Hospital & Health Centers, its officers and personnel and any physician and/or medical student acting under the supervision of a licensed physician providing medical or surgical services to any child named on the reverse side of this form may rely upon the consent of authorization executed by the above named appointee with the same force and effect as if personally executed by me/us.

The consent and authorization shall include and extend to all matters for which consent or authorization is required under the policies of St. Francis Hospital & Health Centers. In consideration of the services that are rendered to any child named on the reverse side of this form, pursuant hereto, we agree to pay for all such services. This authorization shall be in effect until either
a) date _____ (no longer than 60 days)
b) or until revoked in writing.

Authorization is valid for 60 days maximum. Cancellation must be submitted in writing.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Full Name of Physician: _____

Phone: _____

Health Insurance Provider: _____

Insured: _____

ID Number: _____ Policy Number: _____
(If possible, please attach a copy of your insurance card.)

In the event parents are divorced, the form should be completed by the custodial parent. If the child(ren) is under guardianship, the guardian should execute this authorization.