

Authorization form:
One form needed per child

THE DOCTOR IS IN

Please review this form with adults who may be caring for your child or children. You'll feel better knowing that they know what to do if a child becomes sick or is injured, and they will feel better knowing that you trust them to act in your child's best interest.



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One form needed per child

**Immediate Care Center
At US 30 and Burr Street
In Schererville**

Phone: (219) 769-1DOC (1362)
Toll Free: (866) 833-2729
Fax: (219) 769-8298

Mailing Address:
5521 W Lincoln Hwy, Suite 1A
Crown Point IN 46307



If your child needs help when you're not around, you'll be glad you authorized **Immediate Care.**



An independently owned affiliate of
The Immediate Care Centers

For more information, visit our website today:
www.immediatecare.biz

We gladly accept Visa, MasterCard, Discover and
American Express.



Immediate Care Centers
Open 365 Days a Year
No Appointment Needed

Authorization for Treatment of a Minor (one form needed per child)

When you must entrust the care of your child (or children) to another, this form ensures that quick, high-quality health services are available from Unity Immediate Care Center should your child become ill or injured. Simply complete this form (one per child) and keep it in a safe but accessible place. Be sure to leave it with the adult caring for your child in your absence. Additional copies of this form are available from Unity Immediate Care Center, and remember, **THE DOCTOR IS IN! We're open 7am—11pm 365 days a year with no appointment needed!**

Every attempt will be made to contact you should your child become ill or injured, but this authorization ensures that care can be provided more quickly if you cannot be reached.

I, _____, being the parent or legal guardian of _____, born on _____ delegate to _____ (name of person/agency) the authority to consent for medical and/or surgical treatment of this minor by a licensed Indiana physician should his/her condition so require it in my absence. I impose no specific limitation or prohibitions regarding treatment other than those that follow (if none, so state): _____ . This authorization is effective for the following time period (dates) from _____ to _____. I certify I have read this form and understand its contents. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. I acknowledge I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

Parent/Guardian's Signature

Parent/Guardian's Name (please print)

Parent/Guardian's Home, Cell, and Work Phone Numbers

Parent/Guardian's Home Address

City, State, Zip of Parent/Guardian

Emergency phone number (where we can reach you while you're away)

Other Contact Person

Relationship Phone Number

Witness' Signature

Witness' Name (Print)

Child's Primary Care Physician & Phone (may be needed for follow-up care or referral)

Child's Allergies, if any, including medication

Child's Chronic/Existing Diseases or Medical Problems (e.g. diabetes, epilepsy)

Medicines your Child is Taking Now

Date of Child's Last Tetanus Booster

Medical Insurance Carrier (a copy of the insurance card would be helpful)

Member's Name & Employer

Insurance Company Address

City, State, Zip

Insurance ID #, Benefit Code, Plan Information

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