MORRIS HOSPITAL AUXILIARY
150 WEST HIGH STREET
MORRIS, IL 60450
Morris Hospital Volunteer Program for High School Students

# PARENT CONSENT AND AUTHORIZATION FOR MEDICAL TREATMENT

## PARENT CONSENT

1. _____ *has my permission and my support to serve as a volunteer at Morris Hospital.*
2. *My child's birthdate is _______________.*
3. *I give my consent for Morris Hospital Volunteer Services Department to contact my child by phone and/or email for the purpose of volunteer scheduling and notification.*
4. *I give my consent for my child to comply with QuantiFERON®-TB Gold testing and Influenza Vaccine Guidelines, and I consent to allow Morris Hospital and Healthcare Centers to administer TB testing before the start of my child's volunteer service.*
5. *I give my consent for my child to complete Morris Hospital's online background screening. I understand all Morris Hospital & Healthcare Center volunteers are required to complete a background screening to protect the safety of patients, employees, visitors and volunteers. I also understand background screenings are conducted via Raptor Technologies, a secure online system where volunteers can confidentially enter their own information and where all information will remain confidential and will not be shared with third parties.*

*Parent/Guardian Signature*_____ *Date*_____

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## PARENT AUTHORIZATION FOR MEDICAL EMERGENCY TREATMENT:

As a parent and/or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: _____

Name of Parent/Guardian: _____ Relationship to Minor: _____

Address: _____

Parent/Guardian Primary Phone: _____ Parent/Guardian Secondary Phone: _____

Parent/Guardian Email: _____

Family Physician Name: _____

Family Physician Phone: _____

Specific medical allergies, chronic illness or other conditions: _____

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_____

Other Contact in Case of Emergency:

Name: _____ Relationship to Minor: _____

Address: _____

Primary Phone: _____ Secondary Phone: _____

*Release is only intended for times when minor is volunteering with Morris Hospital and Healthcare Centers.*

*This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.*

*Parent/Guardian Signature*_____ *Date*_____