

SHRINERS HOSPITALS FOR CHILDREN

CONDITIONS OF ACCEPTANCE

Name of Child: _____

If accepted, the parents/legal guardians agree:

1. The undersigned certifies that the information supplied to Shriners Hospitals for Children is true and complete to the best of my/our knowledge. By signing below, I/we certify that I am/we are the natural or adoptive parents or legal guardian of the child named above, and that I am/we are legally authorized to consent to medical care of the child. I/we agree to notify the hospital if there is any future change in this relationship
2. I/we authorize such hospital care encompassing laboratory, diagnostic, and medical treatment including outpatient care, as the Chief of Staff or his assistants or designees shall, in their judgment, deem necessary.
3. I/we may be asked to consent to the use or transfusion of blood and blood products for my child if deemed necessary. I/we have the right to withhold this consent. If I/we withhold consent, I/we agree that my child's physician in his or her sole discretion, having deemed the use of transfusion of blood and blood products necessary, may discharge my child from the hospital so that I/we can make arrangements for treatment at another hospital of my/our choice.
4. The child's health information may be used by Shriners Hospitals for Children for treatment of the child; for payment for outside services; and for hospital operations.
5. In addition, I/we may be asked to authorize the use of the child's health information for scientific and educational purposes. The information used may include the nature of the child's medical conditions, operations or procedures performed and the results, the results of diagnostic studies, x-rays, films and photographs. I/we understand that Shriners Hospitals for Children will use its best efforts to ensure that the child's identity is not revealed unless I/we specifically authorize identification of the child in writing.

Witnessed by: _____

Signature of Father or Legal Guardian

Relationship to child: _____

Signature of Mother or Legal Guardian

Date: _____

Signature of Patient (if 14 years of age or older)