Parent/Guardian Consent form for Minors attending Mater Dei Hospital

DATE:_____

To Whom it May Concern,

I, the parent/guardian _____(NAME, SURNAME) declare that I have full legal custody of _____(NAME, SURNAME) _____ (DATE OF BIRTH)

living at (HOME ADDRESS) _____
_____

I give permission SOLELY to the below individual(s) to take _____ to Mater Dei Hospital Malta in the event of any acute medical and/or surgical emergency. I authorise the medical staff to examine and assess him/her when accompanied by this/these individuals without the need for calling us for confirmation as well as to consent for any blood tests, x-ray, ultrasound, CT scan, MRI, anaesthetic, surgical intervention, blood transfusion, treatment and any other necessary care. I certify that the information provided is correct and that the nominated person(s) has/have fully accepted the responsibility for my child.

NAME AND SURNAME	RELATIONSHIP TO MINOR	ID/PASSPORT NUMBER	CONTACT NUMBER

_____

SIGNATURE AND NAME IN BLOCK LETTERS

I.D/passport number :_____

Mobile: _____

Please send the form and a copy of passport or ID of the individual filling in the above form to the following email address: ped.mdh@gov.mt.