RWJBarnabas HEALTH | Jersey City Medical Center

Consent for Emergency Medical Treatment

VOLUNTEER:_____DATE OF BIRTH: _____

Any person under the age of 18 cannot authorize treatment for himself/herself or someone else. If your child is in need of medical treatment while volunteering his/her services at Jersey City Medical Center, every attempt will be made to contact you or your designated responsible adult in order to obtain consent for medical treatment.

By your statements and signature below, it is understood that you are granting consent for emergency medical treatment to be rendered to the above minor volunteer.

_____

In the event that medical treatment is required, please contact one of the following:-

Parent/Guardian: _____
Address: _____
_____
Telephone: _____

Parent/Guardian: _____
Address: _____
_____
Telephone: _____

Designee: _____
Address: _____
_____
Telephone: _____

Family Physician: _____
Address: _____
_____
Telephone: _____

In the even that none of the above can be contacted, I hereby give my consent for medical Treatment to be rendered to _____ (Volunteer name) in the Jersey City Medical Center Emergency Room.

Parent/Guardian Signature: _____ Date: _____

Relationship: _____

355 Grand Street
Jersey City, NJ 07302

201.915.2000

rwjbh.org/jerseycity