

IN LIEU OF INSURANCE CONSENT FORM
Spring String Thing 2011

I (we) _____ and _____,
parents of _____ (age _____,
born _____) give consent to the medical and emergency staff of
Rockingham Memorial Hospital in Harrisonburg, VA, to administer any treatment
(including, but not limited to: x ray, examination, anesthetic, medical, surgical or
dental diagnosis and hospital care) that is considered necessary in the best
judgment of attending or emergency personnel. This consent is valid May 20,
2011- May 22, 2011. **We accept total financial liability for any medical care
given to our child since we have no health insurance.**

Signed,

_____ date _____

_____ date _____

address _____

home phone _____

father's work _____ cell _____

mother 's work phone _____ cell _____

child's doctor _____

address _____

phone _____

Please return this form AND the medical information form.