PATIENT NAME (Print): ____________________________  DATE: ____________  TIME (Military): ____________

1. CONSENT:
I authorize the performance upon ____________________________________________________ of the following procedures: [a] routine diagnostic and therapeutic procedures; [b] special diagnostic and therapeutic procedures to include: umbilical catheterization, spinal tap, suprapubic tap, phototherapy; [c] medical treatment including: oxygen and ventilator use, intravenous fluids, medications, and immunizations advisable and necessary for the care of my child.

I consent to performance of these procedures / treatments under the direction of Dr. ________________________ . These procedures / treatments may be performed by him / her, or anyone whom he / she may designate.

2. RISKS:
These procedures / treatments and their respective risks have been explained to me, to my satisfaction, by Dr. ________________________ . Any questions that I have concerning these procedures / treatments have been answered to my satisfaction.

3. BLOOD TRANSFUSIONS:
I have been advised that my child may need a transfusion of blood and / or blood components during this hospitalization. I consent to this treatment if deemed medically necessary.

The precautions taken, including the testing and screening of the donor and his / her blood for HIV, hepatitis, and CMV generally prevent the complications of transfusions. I understand, however, that risks are not totally eliminated.

I acknowledge that my physician's explanation was given to me in terms which I understand. The explanation included the risks and complications of the proposed treatment including transmission of potentially fatal infectious diseases such as hepatitis and HIV.

☐ I GIVE MY CONSENT for my baby to receive blood and / or blood components as determined by my baby's physician, as such are necessary for my baby's well-being.

☐ I DO NOT CONSENT for my baby to receive blood and / or blood components under any circumstance.

4. NO GUARANTEE:
No guarantee or assurance has been given to me by anyone as to the results that my be obtained from the procedure and treatment covered by this form.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT, THAT THE EXPLANATIONS REFERRED TO THEREIN HAVE BEEN MADE, AND THAT ALL BLANKS REQUIRING INSERTION OR COMPLETION WERE FILLED IN BEFORE I SIGNED.

_________________________________________  ________________________________
PARENT / GUARDIAN'S Signature  WITNESS Signature

PART OF THE MEDICAL RECORD

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