COLUMBUS REGIONAL HOSPITAL

Authorization to Consent to Medical Treatment for Minor Child

Please print all information

This consent form should be taken with the child to the hospital or medical provider's office when the child is taken for treatment.

I/We, _____, parent(s)/legal guardian(s) of _____, born_____, 20_____, do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my/our minor child while said child is under the care of _____ and I am/We are not reasonably available by telephone to give consent. Designee is at least 18 years of age and I/We accept responsibility for all charges related to any medical treatment or hospitalization rendered by reason of this authorization.

This authorization is effective from _____ to _____.

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Witness Signature Witness Name (please print)

Family home address: _____

Telephone: Parent/Guardian 1 Home/mobile:_____ Work: _____
Parent/Guardian 2 Home/mobile:_____ Work: _____

Medical Insurance Company: _____

Policy #:_____ Preferred Hospital:_____

Additional information will assist in treatment but is not required.

Last Tetanus Shot:_____ Allergies to drugs or foods: _____

Special Medications, Blood Type or Pertinent Medical Information:_____

_____

Child's Medical Provider:_____ Phone:_____

If there are any custody orders that address legal custody of the minor child, copies must be attached to this authorization. Healthcare providers have the right to rely upon the representations made by the parent(s) legal guardian(s).

ADM-13 (11/21/2024) Buff Card

COLUMBUS REGIONAL HOSPITAL
2400 EAST 17TH STREET, COLUMBUS, IN 47201
800.841.4938 812.379.4441
crh.org

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PATIENT LABEL
OR
Patient Name:_____
DOB:_____/_____/_____
MR #: _____