COLUMBUS REGIONAL HOSPITAL
COLUMBUS REGIONAL HEALTH PHYSICIANS, LLC
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:______________________________

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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).

Doc type: Auth for Med Treatment of Child Pt Level

ADM-13 (03/17/2025) Buff Card

Columbus Regional Hospital
Columbus Regional Health Physicians, LLC
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 #: ____________________________

Accessible Document