

Dear Parent or Legal Guardian:

Columbus Regional Hospital provides this form to expedite your child's receiving medical care when you are away from home. Fill it out completely, have it witnessed and leave it with the person caring for your children. The completed form needs to be presented at the Hospital when treatment is sought for your children.

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT FOR MINOR CHILD

Name	City
, do hereby state that I am the natural parent or legal guardian of	
State / Zip	horn on / /
Child's Name	_,, born on//,
who resides with me.	·
I authorize St. Paul Lutherar	<u>) </u>
adult who resides at Columbus	Jame
examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to the minor	
child under the general or special supervision and on the advice of any physician or surgeon licensed to practice	
in Indiana. I give permission to admit such visitors to Emergency Department, surgery and/or delivery rooms that	
are sanctioned in the policies established by the Board of Trustees of Columbus Regional Hospital.	
Signature of Parent(s) or Guardian:	Date:
Witness:	Date:
Child's Doctor:	Phone:
Parent's Doctor:	Phone:
Child's Allergies to Drugs (penicillin, etc. if any):	
Date of last Tetanus Immunization:	Medicine child is taking:
Choice of Specialists:	Expiration Date of this Form:
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Authorization to
Consent to Medical Treatment
for Minor Child

COLUMBUS REGIONAL HOSPITAL

2400 East 17th Street, Columbus, Indiana 47201 1-800-841-4938 812-379-4441 www.crh.org PATIENT LABEL

OR

Patient Name:

DOB:

MR #:

ADM-13 (11/05/14) buff:card