CRAWFORD MEMORIAL HOSPITAL

1000 N. Allen Street Robinson, IL 62454

ONE CHILD PER FORM

Effective Dates: _____ to _____

☐ Check if this form will be valid until your child reaches the age of 18 years, unless specified by the above effective dates

Proxy Medical Consent Form

Child's Name _____

Date of Birth _____ Home Phone # _____

Father's Name _____ DOB_____

Father's Employer _____ Phone # _____

Mother's Name _____ DOB_____

Mother's Employer _____ Phone # _____

Insurance Company _____ ID # _____

Child's Physician _____ Office #_____

List of Allergies _____

Routine Medications _____

Past Medical History _____

_____

_____

LIST OF PEOPLE WITH PERMISSION TO SIGN FOR MEDICAL TREATMENT:

1. _____Cell Phone #_____ Work phone # _____
2. _____Cell Phone #_____ Work Phone #_____
3. _____Cell Phone #_____Work Phone # _____
4. _____Cell Phone #_____Work Phone # _____

Additional Comments _____

I/We authorize the above named individual(s) to consent to treatment and authorize the billing of the insurance and/or parent/guardian of this form. This allows the proxy to consent for medical treatment, clinic visits, and minor, in-office procedures. Surgeries require the consent of a patient/guardian.

PARENTS' SIGNATURES

Mother's Signature _____ Date _____

Father's Signature _____ Date _____

Witness' Signature_____ Date _____

Please check if:

☐ Second parent unavailable to sign ☐ Contact information is not available ☐ Sole custody applies

Revised 11/2022