



## Cheboygan Memorial Hospital Authorization to Consent for Medical Care Treatment

Anytime you and your child(ren) will be separated, it's a good idea to leave written permission with your caregiver to assure prompt medical treatment. In life-threatening emergencies, care is always provided immediately; in other cases where medical treatment is needed, written consent may spare your child an extended wait for care. Your authorization will allow for prompt treatment and the hospital will still make every attempt to contact you.

Below is a form which may be completed and given to your caregiver(s) to keep. Do not exceed a one year time period. Please note that notarization is no longer required and that this form allows space to name specific individuals to be listed as **Authorized to Consent for Medical Care** for your child(ren). As always, keep a copy for your own records.

If you have questions, please call CMH Patient Access at (231) 627-5601.

**Cheboygan Memorial Hospital • 748 Main Street, Cheboygan, Michigan 49721 • (231) 627-5601 • www.cheboyganhospital.org**

### CHEBOYGAN MEMORIAL HOSPITAL AUTHORIZATION TO CONSENT FOR MEDICAL CARE TREATMENT

I, \_\_\_\_\_, hereby request and permit Cheboygan Memorial Hospital physician or other  
Parent or Guardian  
 physicians he/she may designate, and Cheboygan Memorial Hospital personnel to render to my child(ren) listed below, any medical and/or surgical treatment he/she may require during the period of \_\_\_\_\_ to \_\_\_\_\_ .  
 (not to exceed one year)

Child's Name	Doctor	Allergies	Insurance	Immun. Up-to-date?
_____ Birthdate	_____ Phone No.		_____ Policy No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Birthdate	_____ Phone No.		_____ Policy No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Birthdate	_____ Phone No.		_____ Policy No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Birthdate	_____ Phone No.		_____ Policy No.	<input type="checkbox"/> Yes <input type="checkbox"/> No

#### Authorized individual(s) who may consent for care for my child(ren):

Name	Phone Number	Relationship to Child

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, ZIP

\_\_\_\_\_  
Daytime Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Evening Phone

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, ZIP

\_\_\_\_\_  
Daytime Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Evening Phone