Designation of Another Person to Consent for Treatment

It is best that children are brought for treatment by a parent or legal guardian. However, there may be times when that is not possible and you need others (babysitter, friend, or family member) to act on your behalf.

Should your child need to be seen at Nationwide Children's Hospital, we must have **your written consent** to allow the person you select to seek treatment and sign the consent form. **This person must be 18 years of age or older.**

Please complete the following:

I, (Full Name of Parent or Legal Guardian) _____

(Address) _____

(Home Phone) _____ (Mobile Phone) _____

(Work Phone) _____

(Child's Full Name) _____

(Child's Date of Birth) _____

I give the following person(s) permission to seek treatment and provide consent for such treatment on my behalf.

_____ _____

Full name Relationship

_____ _____

Full name Relationship

My permission for the people listed above begins on the date of my signature below. It will stay in force until cancelled by me in writing. You may e-mail your request to cancel to the Health Information Management Department at HIMMedicalRecordSupportServices@nationwidechildrens.org. For fastest service, please attach a copy of this original Designation form with your e-mail.

X_____ _____

Signature of Parent/Legal Guardian Date and time (required)

Completing the attached medical history sheet, while not required, can be a helpful communication tool between you and your child's provider in your absence.

DO NOT FORGET!!! Make copies of this form and the medical information sheet if you choose to complete it. Provide them to your designated person(s) to bring to your child's visit to Nationwide Children's. Keep a copy for yourself. Put it in a safe place.

Medical Information Sheet

Name of Child:

_____

(Last) (First) (Middle Initial)

Date of Birth: _____

Specific Concerns for Today's Visit:

_____

_____

_____

Allergies:

_____

_____

_____

Past Hospitalizations (list dates and reasons):

_____

_____

_____

Medicines Child Takes (include over-the-counter):

_____

_____

_____

Other information:

_____

_____

_____

_____ _____

Parent/Legal Guardian Signature Date and time (required)

Notice to Cancel Designation of Another Person to Consent for Treatment Form

I, (parent/legal guardian) _____,

am the parent/legal guardian of (child's full legal name) _____

_____,

Address _____,

Home Phone _____ Work Phone _____.

As of today's date, cancel permission for (person's name) _____

_____

to consent for treatment of my child.

X_____ _____

Signature of parent/legal guardian Date and time (required)

To cancel permission, e-mail the Health Information Management Department at HIMMedicalRecordSupportServices@nationwidechildrens.org. For fastest service, please attach a copy of this original Designation form with your e-mail.