I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent or legal guardian and financial guarantor of

(Name of Parent or Legal Guardian)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, born on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby consent to

(Minor’s Name) (Date of Birth)

(Initial next to all that applies):

\_\_\_\_\_\_\_ Routine/preventative care \_\_\_\_\_\_\_ Lab tests \_\_\_\_\_\_\_ Vaccinations/Immunizations

\_\_\_\_\_\_\_ While my child is under the care of Cheyenne Regional and if I am not reasonably available by telephone to give consent to any other medical care (including the administration of anesthesia) determined by a physician to be medically necessary for the welfare of my child

I give authorization to the below listed individuals to act on my behalf related to the care I initialed above. I understand that I will remain the legal and financial guarantor.

Full Name and phone number of individuals authorized to bring the above named minor on my behalf:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization is effective from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Not to exceed 1 year).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Parent or Legal Guardian\* Print Parent or Legal Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Witness Witness Signature Date

***ADDITIONAL INFORMATION***

**A government issued photo ID of the above-identified representative must be provided to the hospital or physician's office when the child is taken for treatment unless emergent circumstances prevent that from occurring.**

**Revocation can be made in writing to the CRMG Clinic or CRMC Registration**

\* The legal guardian MUST provide copies of court documents ordering the legal guardianship over the child to CRMC to place in the child’s medical record.

\*\* Cheyenne Regional will not delay the provision of a medical screening exam (MSE), stabilizing treatment, or appropriate transfer, or otherwise engage in any activities that would discourage an individual from seeking emergency medical care, in order to inquire about the individual’s method of payment or insurance status.

**\*\*\*Cheyenne Regional use only\*\*\***