



NEUROLOGY & SLEEP SCIENCES  
COLUMBUS REGIONAL HEALTH

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**Treatment of Minor/Incapacitated Adult Consent**

The following is designed for those situations where minors or incapacitated adults are unaccompanied by parent or legal guardian. The Medical treatment authorization gives authority to a designated adult to receive medical care, treatment for a minor child or incapacitated adult. Medical care cannot be provided to a minor or incapacitated adult without written approval by a parent or legal guardian unless there is written consent authorizing an agent.

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*Minor's Full Name*

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*Minor's Date of Birth*

I do hereby authorize Neurology and Sleep Sciences to provide medical treatment of above mentioned minor or incapacitated adult with the following people to act as a designated agent in my absence.

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*Parent or Legal Guardian signature*

*Date*

**Designated Agents:**

*Name*

*Relationship to child or incapacitated adult*

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