

Patient Name: _____ Date of Birth: _____ SS#: _____

Security Code: _____ County of Residence: _____

PERMISSION FOR INPATIENT TREATMENT: YES NO

AUTHORIZATION TO FOLLOW-UP: (Number) _____

PERMISSION TO ATTEND SCHOOL: (Name) _____

Grade: _____ (Don't forget school form) IEP _____ Absence Problem _____

Permission to inventory property and remove strings: YES NO

Permission to use cell phones while inpatient YES NO

Telephone list: **(Relationship/SS/BD of person giving consents)**

PERMISSION FOR IBUPROFEN (Notes) YES NO

MARKETING SIDE

RECENT INFECTIONS: mrsa cdiff current

ATB/steroids: Exposure to Covid Exposure to BB/Lice/Scabies

EMS FORM: ALLERGIES: _____

ANY CURRENT MEDICAL CONDITIONS: _____

Consents obtained by (staff member): _____

Please send completed forms to the following:

Email: admissions@suncolumbus.com • **Mail:** 900 E Dublin Granville Rd, Columbus, Ohio 43229 • **Phone:** (614) 796-0510