



**THE JOHNS HOPKINS
HOSPITAL**

DISPOSITION CONSENT FORM

**(FOR FETUSES OVER 20 WEEKS, YOUNGER FETUSES WITH FETAL
DEATH CERTIFICATES, AND NEONATES LESS THAN 30 DAYS)**

Child's Name: _____

Date of birth: _____ Child's JHH Medical Record #: _____

or

Mother's JHH Medical Record #: _____

I, _____, represent that I am the parent/guardian/other next of kin of this child.
(Insert your name) (Circle one of the above)

My instructions for disposition of my child's body are as follows:

- I assume full responsibility for the funeral arrangements.
- I give permission to the Maryland State Anatomy Board to perform the final disposition (perform a cremation and bury the ashes at Springfield State Hospital in Sykesville, Maryland).

Signature of parent/guardian/next of kin

Printed name of parent/guardian/next of kin

Telephone number of parent/guardian/next of kin

Address of parent/guardian/next of kin

Signature of clinician obtaining consent

Printed name and pager number of clinician

Date

ADMITTING OFFICE: _____

