



CONSENT BY PROXY FOR NONURGENT PEDIATRIC CARE FORM

I appoint _____ of _____
(Name) (Address)
who is my child(ren)'s _____ as my proxy decision maker
(specify nature of proxy's relationship to children)

for consenting to nonurgent medical care for my children listed below. I have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. Protected patient health information may be shared with the proxy to facilitate informed decision making.

Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

LIMITATIONS

Identify any limitations on the kinds of medical services for which this consent by proxy is given. If none, state "none".

Identify any limitations on the time frame for which this consent by proxy is given. If none, state "none".

CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me regarding the health care of my children at the following telephone number(s). If you are unable for any reason to contact me, you may rely on the proxy decision maker for consent.

Parent's/
Guardian's Name: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

Parent's/
Guardian's Name: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

IN WITNESS WHEREOF, the undersigned have executed this instrument as of the _____ day of 20_____.

Parent or Legal Guardian Signature

Parent or Legal Guardian Signature

Proxy Decision Maker Signature

Print Name

Phone

Address

If Parent/Guardian are not available for signature:

Date of Phone Call:

Time of Phone Call:

Name of Responsible Party spoken to

Relationship to Patient of person spoken to

Name of Telephone Call Witness #1

Name of Telephone Witness #2

Signature of Telephone Call Witness #1

Signature of Telephone Call Witness #2