CHEMED

CONSENT FOR TREATMENT OF MINOR & OPTIONAL PROXY AUTHORIZATION

Summary (Please Read Before Signing):

- By signing, you give CHEMED permission to provide routine and necessary medical care to your child(ren) in your absence.
- You may designate a proxy who can bring your child to visits and provide consent when you are not available.
- You may place limits on the types of services this consent covers.
- This consent remains in effect until revoked in writing or until the expiration date you specify.
- Under New Jersey law, minors may consent on their own for certain services (e.g., pregnancy care, STD/HIV testing, substance use treatment, and some mental health care at age 16+)

☐ My child under the age of 18 will be coming to the office with a designated proxy.

1. **Authorization for Treatment**

I am the parent/legal guardian of the following child(ren) and have the legal right to consent to their medical treatment. I understand and acknowledge that there may be occasions where I am unable to be present for my child(ren)'s medical appointment and/or visit and that CHEMED and its personnel will provide care in my absence.

I hereby authorize CHEMED and its personnel to deliver routine, preventive, urgent, and other medically necessary care to my child(ren) listed below in my absence.

Name: _____ DOB: _____

Name: _____ DOB: _____

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2. **Proxy Authorization (Optional)**

I authorize the following individual(s) to consent to medical treatment for my child(ren) when I am unavailable.

Name: _____

Relationship: _____

Phone: _____

Email: _____

Name: _____

Relationship: _____

Phone: _____

Email: _____

If the medical care needed is not routine and is not an emergency, CHEMED will make reasonable efforts to contact me at the numbers below. If I cannot be reached, I authorize the proxy named above (if applicable) to consent to such care on my behalf. In an emergency, CHEMED may proceed with treatment as permitted by law.

3. **Limitations on Medical Services**

Please specify any limitations on the medical services
for which this authorization applies. If none, write "none".

_____

_____

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4. **Contact Information**

Parent/Guardian Name: _____

Daytime Phone: _____

Evening Phone: _____

Cell Phone: _____

Email: _____

Parent/Guardian Name: _____

Daytime Phone: _____

Evening Phone: _____

Cell Phone: _____

Email: _____

5. **Duration & Revocation**

This authorization remains valid until:

☐ A specific expiration date: _____

☐ Revoked by me in writing

I understand that I may revoke this authorization at any time by notifying CHEMED in writing. Revocation will not affect care already provided in reliance on this authorization.

6. **Acknowledgement**

I understand that protected health information may be shared with the proxy I have designated to facilitate informed decision-making.

7. **Signatures**

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Parent/Legal Guardian Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

If consent is provided by phone (when signature unavailable):

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