# Consent by Proxy for Non–Urgent Pediatric Care

**Purpose:** This form may be used to allow an adult other than a parent to serve as a proxy decision maker for the routine medical care and services.

I (We) appoint the following individuals:

1. _____

Name Phone Relationship to Patient

_____

Address

2. _____

Name Phone Relationship to Patient

_____

Address

As my (our) proxy decision-maker for consenting to non-urgent medical care for my (our) children listed below. I (we) 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. I (we) have been advised that protected patient's health information may be shared with the proxy to facilitate informed decision making.

Patient Name _____ D.O.B. _____

Patient Name _____ D.O.B. _____

Patient Name _____ D.O.B. _____

Patient Name _____ D.O.B. _____

**Limitations**

Identify any limitations on the types of medical services for which the 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 (us) regarding the health care of my (our) child(ren) at the following telephone numbers(s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

Parent's Name: _____ Parent's Name: _____

Daytime Phone: _____ Daytime Phone:_____

Evening Phone: _____ Evening Phone:_____

Cell Phone: _____ Cell Phone: _____

This consent will remain in effect for one (1) year from the date of the signature unless otherwise stated below.

This consent is to remain in effect until _____, 20_____

I am also signing that I will be financially responsible for all charges that are due or become due for the above patient.

_____

Parent or Guardian Signature Date Parent or Guardian Signature Date