Alternate Caregiver Consent Form

I authorize the following individual(s) to bring my children to their appointments:

Name:_____ Relationship to child:_____

Name:_____ Relationship to child:_____

Name:_____ Relationship to child:_____

Name:_____ Relationship to child:_____

I attest that the above-named individual(s) are 18 years of age or older as of this date.

I authorize the above-named individual(s) to consent for necessary medications, immunizations, procedures and possible emergency transportation. Bloom Pediatrics may relay any medical information, including private health information, about my child that is necessary for the above-named individual(s) to provide informed consent to the treatment.

I understand that the provider will communicate their findings and treatment plan to the caregiver who brings the child, and that under most circumstances, a follow-up call to me personally should not be necessary. I agree to be responsible for any fees for services requested by the above-named individual(s) when permitted by my insurance carrier(s).

I agree to hold Bloom Pediatrics and its staff harmless for any disagreement between the above-named individual(s) and myself regarding treatment decisions.

I attest that I am the parent or legal guardian of the following children and that I have the legal authority to make this agreement. I understand that I can revoke this authorization for any or all of these individuals in writing at any time.

Children covered by this consent:

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____Date: _____