Parent or Legal Guardian Designation to Permit Another Individual to Consent for Health Care

I (we) appoint the following person(s) as my (our) proxy decision maker(s) for consenting to non-emergent 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 am advised that protected patient health information may be shared with the proxy to facilitate informed decision-making.

Patient Name _____ DOB _____
Patient Name _____ DOB _____
Patient Name _____ DOB _____
Patient Name _____ DOB _____
Patient Name _____ DOB _____

Adult #1 Information:

Name: _____
Phone number: _____
Relationship: _____

Adult #2 Information:

Name: _____
Phone number: _____
Relationship: _____

Adult #3 Information:

Name: _____
Phone number: _____
Relationship: _____

LIMITATIONS

This consent shall be valid until and including this date _____, OR it is terminated by one of the individuals signing the authorization below, OR it is revoked for a reason listed below.

As to the above-named child(ren), the Adult(s) is/are authorized to consent to:

Annual check-ups - which may include, but are not limited to, physical examination, evaluation or screening tools, lab work, routine testing, developmental assessment, medication administration, and consenting to recommended vaccinations.

Acute and Chronic “sick” visits and follow-up appointments, such as strep throat, ear rechecks, medication rechecks, medication administration, minor procedures, and walk-in vaccines.

Mental or behavioral health examination visits, such as ADHD, depression, and anxiety.

Revocation

I understand that this designation may be revoked by any of the following:

a. A parent may revoke a designation by notifying the health care professional either orally or in writing, or by any other act evidencing a specific intent to revoke the designation, or by executing a subsequent designation.
b. If both parents have signed this designation, and either of the parents revokes it, the authority of the designee is revoked.
c. A designee must notify all appropriate health care professionals of any revocation of his/her authority.
d. If the parent who signed a designation becomes incapacitated or dies, the designation is revoked.

CONTACT INFORMATION

If the nature of the medical care is not routine or further informed consent is needed, please try to contact me (us) regarding the health of my (our) children at the following telephone number (s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent. If a court has ordered that both parents must agree on health care decisions, both parents must sign this designation

Parent’s Name: _____ Relationship: _____
Daytime Phone: _____ Cell Phone: _____
Signature: _____ Date: _____
Parent’s Name: _____ Relationship: _____
Daytime Phone: _____ Cell Phone: _____
Signature: _____ Date: _____