



Olentangy Pediatrics, Inc.

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Consent for Treatment of A Minor Without A Parent Present (Authorization for Babysitter, Grandparent, Step-Parent, etc. to consent for treatment)

Name of Minor Child: _____ DOB: _____

I, the undersigned parent or legal guardian of the above named minor, know that I may not be available to authorize medical care of said minor child and I wish to appoint someone to act in my place in my absence and to give such authorization. This authorization is intended to give

_____ (name of caregiver) the right to give consent to authorize medical care for the above named minor child.

It is intended that this document be presented to the physician or appropriate hospital or medical representative. It is intended that this authorization relieve the physician, dentist, or other person rendering care from any liability resulting from the inability of me, the parent or guardian of the above-named minor, from signing a consent or authorization to render such care. It is the intent that the above named caregiver shall act in my stead in making such decisions.

This authorization will expire on _____ . Authorization may be revoked at any time with written notice.

Signature of Parent/Guardian

Date

Signature of Parent/Guardian

Date