CONSENT BY PROXY FOR NONURGENT PEDIATRIC CARE

I (we) appoint____,
name of person to whom permission is granted (proxy decision maker)

who is our child(ren)'s ________________________________as my (our) proxy
relationship to child

decision maker for consenting to nonurgent 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. Be advised that protected patient health information may be shared with the proxy to facilitate informed decision making.

Name: ____________________________________ DOB: ________________________

Name: ____________________________________ DOB: ________________________

Name: ____________________________________ DOB: ________________________

LIMITATIONS

Identify any limitations on the kinds of medical services for which this consent by proxy is given. If none, state "**none**." ____
____

Identify any limitations of the time frame for which this authorization 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) 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.

Parent's Name: ____________________ Parent's Name: ______________________

Daytime Phone: ___________________ Daytime Phone: _____________________

Evening Phone: ___________________ Evening Phone: ______________________

Cell Phone: _______________________ Cell Phone: _________________________

IN WITNESS WHEREOF, the undersigned has executed this instrument on

Date: _____________________

Signature of parent or legal guardian: ____

Printed name of person signing this document:__________________________________