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CONSENT BY PROXY FOR NONURGENT PEDIATRIC CARE

I (we) appoint:

_____

(Name) (Address) (Relationship)

_____

(Name) (Address) (Relationship)

_____

(Name) (Address) (Relationship)

as my (our) proxy decision maker for consenting to **nonurgent** medical care for my (our) child(ren) 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 exerise the authority so delegated. Be advised that protectedpatient information may be shared with the proxy to facilitate informed decision making.

CHILD'S NAME: _____ DOB:_____

CHILD'S NAME: _____ DOB:_____

CHILD'S NAME: _____ DOB: _____

CHILD'S 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 on the time frame for which this 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 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:_____

_____ _____

Parent or Legal Guardian Date Parent or Legal Guardian Date

11/05

Consent by Proxy for Nonurgent pediatric care