Alternate Caregiver Consent Form

I authorize the following individual(s) to bring my child to his/her appointments:

Name: _____
Relationship to Child: _____

Name: _____
Relationship to Child: _____

Name: _____
Relationship to Child: _____

I attest that the above named individual(s) are all 18 years or age or older as of this date:
I authorize the individual(s) above to consent to treatment for my child name below. This may include, but is not limited to, consent for necessary medications, procedures, and hospitalization. I agree that Elizabeth A McMorran NP may relay any medical information about my child necessary for the above named individual(s) to provide a full informed consent for treatment.

I understand that the Nurse Practitioner will communicate her 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 Elizabeth A McMorran NP and her staff harmless for any disagreement between the above-namedindividual(s) and me regarding treatment decisions.

I attest that I am the parent or legal guardian of the following child 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 individual(s) at any time.

Child covered by this consent:

Name: _____ Date of birth: _____

_____ _____
Parent/Guardian Name Relationship to Child

_____ _____
Parent/Guardian signature Today's date

OFFICE OF ELIZABETH A MCMORRAN NP
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