



Consent by Proxy for Non-Emergent Pediatric Care Form

Patient _____ (Please Print) DOB _____

I/we appoint _____ (Proxy Name) who is my/our child's _____ (relationship to minor) as my /our proxy decision maker for consenting to non-emergent medical care for my (our) child listed above. Non-emergent, routine medical care is defined as preventative health supervision visits, vaccinations, screening tests, and outpatient encounters for minor illnesses or injuries. I/we, a medically and legally competent adult, have the right as a legal authorized representative 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. The proxy will be required to present a photo ID when accompanying your child to their appointment.

Limitations: Identify any limitations on the kinds of non-emergent medical services 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 to contact me (us) for any reason, you may rely on the proxy decision maker for consent.

Guardian's Name: _____

Proxy's Name: _____

Phone Number: _____

Phone Number: _____

Relationship to Minor: _____

Relationship to Minor: _____

IN WITNESS WHEREOF, the undersigned have executed this instrument as of _____ day of _____, 20_____.

Parent or Legal Guardian (Print)

Witness (Print)

Parent or Legal Guardian (Signature)

Witness (Signature)

This form is valid for one year unless it is updated or revoked by the legal authorizing representative (LAR) or the patient is no longer considered a minor.