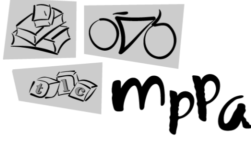

Mesa Pediatrics
Professional Association

Consent by Proxy for Non Urgent Pediatric Care

Patient Name: ______________________________ DOB: ________________
Patient Name: ______________________________ DOB: ________________
Patient Name: ______________________________ DOB: ________________
Patient Name: ______________________________ DOB: ________________

I (we) appoint as our proxy decision maker:
Name: ________________________Relationship to patient: ________________
Name: ________________________Relationship to patient: ________________
Name: ________________________Relationship to patient: ________________

The person named above has my permission to consent to non-urgent medical care for my (our) children listed on this document. I (we) have the legal right to delegate consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority delegated. Be advised that protected patient healthcare information may be shared with the proxy to facilitate informed consent.

Limitations

Identify any limitations for medical services which this consent by proxy is given. If none, state "none".

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____
____

Contact Information

If the nature of the medical care is not routine, please contact me (us) regarding the health care of my (our) children at the following telephone number(s). If you are unable to contact me (us), you may rely on the proxy decision maker for consent.

Parents Name: ____________________
Daytime Phone: ____________________
Evening Phone: ____________________
Cell Phone: ____________________

Parents Name: ____________________
Daytime Phone: ____________________
Evening Phone: ____________________
Cell Phone: ____________________

____
Parent or Legal Guardian Signature

____
Parent or Legal Guardian Signature

____
Date

____
Date

Rev. 10/13/10