Four Seasons Pediatrics

Parent or Legal Guardian Designation to Permit Another Individual to Consent for Health Care

I (we) appoint the following person:_____ ("other adult") as my (our) proxy decision maker for consenting to non-emergent 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. I am advised that protected patient health information may be shared with the proxy to facilitate informed decision-making.

_____	_____
Patient Name	**DOB**
_____	_____
Patient Name	**DOB**
_____	_____
Patient Name	**DOB**
_____	_____
Patient Name	**DOB**

"Other Adult's" Information (please enter all information if known):

Name: _____
Phone number: _____
Relation: _____
Address and/or DOB (if known): _____
_____

(optional)"Other Adult's" Information (please enter all information if known:

Name: _____
Phone number: _____
Relation: _____
Address and/or DOB (if known): _____
_____

(optional)"Other Adult's" Information (please enter all information if known:

Name: _____
Phone number: _____
Relation: _____
Address and/or DOB (if known): _____
_____

LIMITATIONS

This consent shall be valid until and including this date _____, (or) it is terminated by one of the individuals signing the authorization below, (or) it is revoked for a reason listed below.

As to the above named child(ren), the "other adult" is authorized to consent to:

- Yearly check-ups - which may include but are not limited to physical examination, evaluation or screening tools, lab work, routine testing, developmental assessment, medication administration
- Acute and Chronic "sick" visits and follow up appointments, such as strep throat or ear rechecks, and medication administration if needed
- Mental or behavioral health examination visits, such as ADHD, depression, anxiety initial or follow up care
- Influenza vaccination appointments (as getting the influenza vaccine is the sole reason for the appointment)

FOR PROCEDURES OR IMMUNIZATIONS, the parent or legal guardian will need to be contacted directly by clinical staff to obtain informed consent before any action is done. The designee above can not consent to these.

Revocation: I understand that this designation shall be revoked by any of the following:

a. A parent may revoke a designation by notifying the health care provider **either orally or in writing, or by any other act evidencing a specific intent to revoke the designation, or by executing a subsequent designation.**
b. If both parents have signed this designation, and either of the parents revokes it, the authority of the designee is revoked.
c. A designee must notify all appropriate health care providers of any revocation of his/her authority.
d. If the parent who signed a designation becomes incapacitated or dies, the designation is revoked.

CONTACT INFORMATION

If the nature of the medical care is not routine or further informed consent is needed, please try to contact me (us) regarding the health 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.

If a court has ordered that both parents must agree on health care decisions, both parents must sign this designation

Contact Information

Parent's Name:	_____	Parent's Name:	_____
Relationship:	_____	Relationship:	_____
Daytime Phone:	_____	Daytime Phone:	_____
Evening Phone:	_____	Evening Phone:	_____
Cell Phone:	_____	Cell Phone:	_____

Signature w/ date:_____ Signature w/ date:_____