CONSENT BY PROXY FOR NON-URGENT PEDIATRIC CARE FORM

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For families who are ongoing patients of Jonna L. Schmidt, M.D., P.C.

I (we) appoint _____, who is my (our) child's
(print name of person bringing child)
_____ as my (our) proxy decision maker for consenting to non-
(specify nature of proxy's relationship to child)

urgent medical care for my (our) child 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. Be advised that protected patient health information may be shared with the proxy to facilitate informed decision making. *(If you are designating your older, under 18 year old child to be their own proxy, they must be at least 15 years old)

Child's Name: _____DOB:_____

LIMITATIONS
Specify any limitations on the kinds of medical services for which this authorization is given. If none, state "none".

_____

_____

Specify the time frame for which this authorization is given. (Time frame not to exceed one year)

_____

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).

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

_____ _____
Proxy Decision Maker Signature Date Signed by Proxy Decision Maker

_____ _____
Parent or Legal Guardian Name (print) Parent or Legal Guardian Name (Print)

_____ _____
Parent or Legal Guardian Signature Parent or Legal Guardian Signature

_____ _____
Date Signed By Parent Date Signed By Parent