Children's Community Practices

An Affiliate of Nationwide Children's Hospital

Designation of another Person to Consent for Treatment of Minor Child

In the event I, _____, cannot accompany my child, _____, _____,
(parent/legal guardian) (child's name) (date of birth)

to his/her appointment(s). I give permission to the following person(s) to consent to any necessary examination, medical diagnosis and/or medical care including, but not limited to vaccines listed on the AAP's recommended vaccine schedule, to be rendered to the above-named minor child under the general or special supervision and on the advice of any provider of the practice.

1. _____
(name of designee) (relationship to patient)

2. _____
(name of designee) (relationship to patient)

3. _____
(name of designee) (relationship to patient)

4. _____
(name of designee) (relationship to patient)

Expiration of Permission (check one):

_____ This form will remain in effect until revoked by written notice.

_____ This form is VALID ONLY during the following time frame:

Effective date: _____/Expiration date: _____

_____
Parent or legal guardian (Please print name)

_____
Signature of parent or legal guardian Date

_____
Witness (Please print name)-MUST be 18 years or older and NOT the person receiving consent to treat

_____
Signature of witness Date

Instructions: Please provide your child's health insurance card and copay as applicable at each appointment. It is further agreed that if the parent or legal guardian wishes to discuss the medical care with the physician, a telephone consultation may be scheduled.

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