

AGC Pediatrics, LLC



Designation of Another Person to Consent for Medical Care

(Separate form must be filled out for each child)

Our first priority at **AGC Pediatrics**, is the safety and well being of your child. In order for us to maintain and enforce this we must follow certain guidelines issued by Federal and State Law. It is best that children are brought for medical treatment by a parent or legal guardian. However, there may be times when someone other than you takes care of your child.

Patient Name _____ DOB ____/____/____

MRN _____

List anyone who is authorized (other than parent/guardian) to:

#1 Schedule and attend appointments;

Receive and provide disclosure of medical and financial information; to include, but not limited to

Make medical decisions, including, but not limited to vaccines, antibiotic injections, blood draws, minor office procedures, etc.

#2 Call to get patient results or be given patient's results

#3 Pick- up patient's medication prescriptions, medicine/samples

#4 Be used as an emergency contact

#5 All of the above

Please identify which # applies to the individual and place the number at the beginning of the line beside the person's name. **If number is not listed, this form is considered void and will not be used as a consent.**

_____	_____	_____	_____
#	Name	Relationship to Patient	Phone number
_____	_____	_____	_____
#	Name	Relationship to Patient	Phone number
_____	_____	_____	_____
#	Name	Relationship to Patient	Phone number
_____	_____	_____	_____
#	Name	Relationship to Patient	Phone number

Parent/Legal Guardian Signature: _____

Date: ____/____/____