

THOMAS R. BODENSTINE, M.D.
BRADLEY J. WASSERMAN, M.D.
TINA B. STEWART, M.D.
MARY-CASSIE SHAW, M.D.
ANGELICA L. SWIERSZ, M.D.

Oberlin Road Pediatrics

CONSENT BY PROXY FOR NON-URGENT PEDIATRIC CARE

(For families who are ongoing patients of **Oberlin Road Pediatrics**)

I appoint, _____, who is my
(Name) (Address)

child(ren)'s _____ as my proxy decision maker
(Specify Nature of Proxy's Relationship to the Children)

for consenting to non-urgent medical care for my children listed below. I 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.

Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

LIMITATIONS

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

Identify any limitations on the time frame for which this consent by proxy is given. If none, state "none."

CONTACT INFORMATION

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

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

IN WITNESS WHEREOF, the undersigned have executed this instrument as of the ____ day of _____ 200__.

Parent or Legal Guardian

Parent or Legal Guardian

Proxy Decision Maker