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Oberlin Road Pediatrics

CONSENT BY PROXY FOR NON-URGENT PEDIATRIC CARE (Underage Child)

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

I , _____, give my permission for my underage
(Name)

child (Name:) _____ (DOB)_____ to be seen and

treated by Oberlin Road Pediatrics, PA. I have the legal right to delegate such consent.

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:	_____

Proxy Decision Maker: _____ Relationship: _____

Phone: _____ Phone: _____

IN WITNESS WHEREOF, the undersigned have executed this instrument as of the ____ day of _____200__.

_____
Parent or Legal Guardian's Signature