Consent By Proxy For Acute Pediatric Care

Parent or Legal Guardian must attend Well Visits

For families who are ongoing patients of Bay Shore Pediatrics including but not limited to Drs. Skolnick, Chiu, Singh, Bhogte, and God, I(we) appoint _____ (name of proxy), who is my (our) children(s) _____ (nature of relationship to patient) as my (our) proxy decision maker for consenting to nonurgent medical care for my (our) children listed below.

I (we) have the legal right to delegate such consent to the proxy decision maker, who is an adult and legal 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: _____ D.O.B. _____
Name: _____ D.O.B. _____
Name: _____ D.O.B. _____
Name: _____ D.O.B. _____

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

I will be available at the following telephone number during my child'(s) visit. If you are unable for any reason to contact me you may rely on the proxy decision maker for consent.

Parent's Name: _____ Telephone Number _____

Parent's Name: _____ Telephone Number _____

IN WITNESS WHEREOF, the undersigned have executed this agreement.

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

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

Proxy Decision Maker _____ Date _____
(Print Name)_____