Patterson & Tedford Pediatrics
with you every step of the way

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CONSENT BY PROXY TO ALLOW MEDICAL TREATMENT OF A MINOR (2018)

Child's Name:_____ Date of Birth:_____
(Please print)

Child's Name:_____ Date of Birth:_____
(Please print)

Child's Name:_____ Date of Birth:_____
(Please print)

I grant authority to the following to be my legally authorized representative(s) in the medical care of my child(ren) listed above. He or she may consent to all necessary treatment or testing for my child, including authorizing the administration of vaccines. This consent by proxy remains in effect until I rescind it, in writing, at some future date.

Name of Representative:_____ Relationship to Child:_____

Name of Representative:_____ Relationship to Child:_____

Name of Representative:_____ Relationship to Child:_____

Name of Representative:_____ Relationship to Child:_____

Name of Representative:_____ Relationship to Child:_____

Printed name of parent or guardian:_____

Signature of parent or guardian:_____

Date:_____

[ ] I am a parent with legal custody
[ ] I am a guardian with legal custody

Updated 1.1.18

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