orchidhealth
Exceptional, local healthcare

Designation of Another Person to Consent for Child's Medical Care

If I, (parent/legal guardian) _____ , cannot accompany my child,

(child's name)_____ , to the Orchid Health Clinic, I give

permission to (person's name)_____ as follows (check one):

☐ I give permission for this person to seek medical treatment for my child(including any type of procedure) and provide consent for such treatment without having to contact me.

☐ I give permission for this person to seek medical treatment for my child(including any type of procedure) and provide consent for such treatment if attempts to contact me are unsuccessful.

Expiration of Permission (check one):

☐ This form will remain in effect until revoked (by filling out a "revoke consent form")

☐ This form is VALID ONLY during the following time frame:

Effective date: _____ / Expiration date: _____

X _____ _____
(Signature of parent or legal guardian) (Date required)

Address _____

Home Phone _____ Work Phone _____