

Designation of Another Person to Consent for Medical Care

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I, (parent/legal guardian) _____, am unable to accompany my child,
(child's name) _____, to Westfield Pediatrics. Therefore, I give
permission to (person's name) _____ to seek medical treatment for my
child (including any type of procedure or medication) and provide consent for such treatment if
attempts to contact me are unsuccessful.

This form is VALID ONLY during the following timeframe:

Effective date: _____ / Expiration date: _____

X _____

(Signature of parent or legal guardian) (Date and time signed-required)

Address _____

Home Phone _____ Work Phone or Cell Phone _____