Neighborhood Clinic

CONSENT BY PROXY FOR NON-URGENT PEDIATRIC CARE (Underage Child)
(For families who are ongoing patients of Neighborhood Clinic)

I, _____ give my permission for my

underage child (Name): _____ (DOB)_____

to be seen and treated by Neighborhood Clinic, NC. 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 healthcare 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.

Parents Name: _____ Parents 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 the _____ day of _____ , 20_____.

_____
(Parent of legal Guardian's Signature)