

Alternate Caregiver Consent Form

I authorize the following individual(s) to bring in my children to their appointments:

Name: _____ Relationship to my child: _____

Name: _____ Relationship to my child: _____

Name: _____ Relationship to my child: _____

I attest that the above named individual(s) are all 18 years of age or older as of this date.

I authorize the above named individual(s) to consent to treatment for my children. This may include, but is not limited to, consent for necessary medications, vaccinations, procedures and hospitalization. Pediatric Solutions, S.C. may relay any medical information about my child necessary for the above named individual(s) to provide informed consent to the treatment.

I understand that the doctor will communicate his or her findings and treatment plan to the caregiver who brings in the child, and that under most circumstances, a follow up call to me personally should not be necessary.

I agree to hold Pediatric Solutions, S.C. and its staff harmless for any disagreement between the above named individual(s) and myself regarding treatment decisions.

I attest that I am the parent or legal guardian of the following children and that I have the legal authority to make this agreement. I understand that I can revoke this authorization for any or all of these individuals at any time.

Children covered by this consent (list full names and date of birth):

1. _____

2. _____

3. _____

4. _____

5. _____

Parent/guardian's name: _____

Signature: _____

Date: _____