Chillicothe Pediatrics
Designation of another Person to Consent for Treatment of Minor Child

I, _____, cannot accompany my child, _____,
(parent/legal guardian) (child's name)
_____, to Chillicothe Pediatrics. Therefore, I give permission to _____
(child's date of birth) (print person's name)
to consent to any necessary examination, medical diagnosis and/or medical care including, but not limited to, vaccines listed on the AAP's recommended vaccine schedule, to be rendered to the above named minor child under the general or special supervision and on the advice of any provider at Chillicothe Pediatrics.

Expiration of Permission (check one):

_____ This form will remain in effect until revoked by written notice.

_____ This form is VALID ONLY during the following time frame:
Effective date: _____/ Expiration date: _____

_____
Parent or legal guardian (Please print name)

_____ _____
Signature of parent or legal guardian Date

_____
Witness (Please print name)-MUST be 18 years or older and not the person receiving consent to treat

_____ _____
Signature of witness Date

Medical History

List any known allergies, including medications: _____
_____

List any chronic existing diseases or medical problems (asthma, diabetes, epilepsy, etc.): _____
_____

List any medications your child is taking now: _____
_____

Instructions: Please provide your child's health insurance card and copay as applicable to be brought with them to the appointment. It is further agreed that if the parent or legal guardian wishes to discuss the medical care with the physician, a telephone consultation may be scheduled.