Pediatric & Adolescent Center of NW Houston, PA

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CONSENT BY PROXY FOR NON-URGENT PEDIATRIC CARE

This consent form is required if anyone other than a parent or legal guardian brings your child to the office. This includes, but is not limited to, stepparents, grandparents, adult siblings, aunts, uncles, nannies, or family friends.

Patient Information

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Proxy Information

Name of Proxy: _____ Relation to Child: _____

Name of Proxy: _____ Relation to Child: _____

Scope of Consent

The above-named individual is authorized to:

- Accompany my child to office visits.
- Consent to routine, non-urgent medical care and treatment (e.g., physical exams, immunizations, diagnostic tests, prescriptions).
- Receive information regarding my child's care during the visit.

This authorization does not permit consent for:

- Emergency or life-threatening medical care.
- Surgical procedures
- Decisions regarding mental health treatment.

Duration of Consent

This consent is valid from the date of my signature below. I may revoke this authorization at any time in writing.

Acknowledgement

I understand that by signing this form, I am granting the above proxy the right to make healthcare decisions on behalf of my child(ren) in my absence for non-urgent care.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Proxy Date