The solo pediatric practices of
Magdalenne Corso MD, PC; James Resk, MD, PC; Troy Stoeber, MD, LLC; Kristine Bugakov MD, LLC
14279 Glen Oak Road, Oregon City, OR 97045 ❖ 503 657-7629 ❖ 503 557-8651 *fax*

Consent by Proxy for Pediatric Care

We encourage you to accompany your child to appointments whenever possible, but recognize that you may not always be available when your child is in need of medical attention. This form allows you to delegate others to act on your behalf.

I hereby appoint,

First Name	Last Name	Phone	Relationship
First Name	Last Name	Phone	Relationship

as proxy decision maker(s) for consenting to non-urgent medical care for my child(ren) listed below. I have the legal right to delegate such consent to the proxy decision maker(s), who is(are) an adult and legally and medically competent to exercise the authority so delegated. **Be advised that protected patient health information may be shared with the proxy to facilitate informed decision making.**

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

LIMITATIONS

- Specify the appointment type this authorization is approved for:
  - ❑ **Acute care/Sick visits** – Including but not limited to: Throat swabs, wart treatment, cleaning of minor burns, or suturing of minor lacerations.
  - ❑ **Well Child Care/Physicals** – Including but not limited to Immunizations
- Specify the time frame for which this authorization is given. (If no time frame given this form will expire in one year of signature and date):
  - ❑ NONE (never expires) ❑ 1 YEAR ❑ OTHER DATE: _____

PARENTAL CONTACT INFORMATION: If the nature of the medical care is not routine, please try to contact me (or secondary Parent or Legal Guardian) at the following telephone number(s).

1. _____ _____ _____ _____
   Parent or Legal Guardian's Printed Name | Relationship to Patient | Primary Phone Number | Secondary Phone Number

2. _____ _____ _____ _____
   Parent or Legal Guardian's Printed Name | Relationship to Patient | Primary Phone Number | Secondary Phone Number

_____ _____
Parent or Legal Guardian's Signature | Date