Canton Asthma & Allergy
Pediatric & Adult Care

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CONSENT BY PROXY FOR NON-URGENT MEDICAL CARE FOR MINOR

Patient legal Name:______________________________ Date of Birth:_______________ Chart#: _____________

Contact Information: If the nature of the medical care is not routine, please contact the parent(s) regarding the health care of my son/daughter at the following telephone numbers. If unable to contact the parent(s) listed below, you may have the proxy listed make the decision for medical care.

Parent's Name:	Parent's Name:
Cell Phone Number:	Cell Phone Number:
Signature of Parent:	Signature of Parent:

Limitations: Identify any limitations on the kind of medical services for which this Consent by Proxy is given. If none, state NONE.

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Proxy:

I (we) appoint ________________________________ Who is my/our child's ________________________________
Name of Proxy Relationship to child

Address of Proxy:____

Signature of Proxy:____

The listed Proxy has the legal right to make medical decisions on the parent's behalf and who is an adult 18 years old or older. Be advised that protected health information may be shared with the Proxy to facilitate informed decision making.

The listed above Proxy must show picture ID to prove identity and a copy will be made to keep with this signed consent. If Proxy does not have picture ID the minor dependent will not be seen.

Canton Asthma & Allergy Witness: __________________