Texas Children's Pediatrics

DELEGATION OF CONSENT FORM

Patient's Name:	
Patient's Date of Birth:	
Mother / Legal Guardian's Name, Address, and Phone Number:	
Father / Legal Guardian's Name, Address, and Phone Number:	

Statement of Medical Treatment(s)/Procedure(s) to be Given and Purpose of Treatment.
Additional pages may be added if necessary to describe specified medical procedure(s); it must be signed and dated by parent/conservator/legal guardian. Initial to consent for the following treatments.

Initial Below

_____ Routine pediatric well care including immunizations.

_____ Medical evaluation and management of pediatric outpatient illnesses including both acute and chronic diseases.

_____ Minor in-office procedures

Treating Physician (also includes the physicians and advanced practice providers partnered with the treating physician):	

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I/We as the parent(s), conservator(s), or legal guardian(s) of the minor child named above hereby appoint the individuals listed below in order of appearance to act on my/our behalf to consent to the above specified medical treatment(s)/procedure(s) when I/we am/are reasonably unavailable to grant such consent. If I choose to terminate this delegation I must contact my practice.

Name of Individual	Relation to Patient (Minor Child)	Contact Information

Initial Below

_____ I/We understand that in the event that I/we am/are unavailable to grant consent on behalf of my minor child, the consent of the individual identified above, who I/we have granted authority to consent on behalf of my minor child too, will be considered sufficient for the specified medical treatment(s)/procedure(s) specified above.

_____ I/We will indemnify and hold harmless, from any expense or claim of any nature, any entity that provides or causes to be provided examination, treatment, or hospital care under this Delegation of Consent (except to the extent such entity is negligent therein). I understand that I am responsible for payment of all charges that result from care provided by TCP, including amounts not covered by my health plan.

By signing below, I acknowledge that I have read, understand, and agree to this Delegation of Consent.

_____ _____
Parent/Conservator/Legal Guardian Date

_____ _____
Parent/Conservator/Legal Guardian Date:

_____ _____
Witness (Sign & Print Name) Date:
(If document is signed by Parent/Conservator/Legal Guardian at a TCP practice, a witness must sign)

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For Translator to complete if applicable:

I have accurately and completely read this document to _____

(parent(s)/conservator(s)/legal guardian(s)) in their primary language. He / She understood all of the terms and conditions and acknowledged his/her agreement and authorization thereto by signing the document in my presence.

_____ _____
Translator/Reader (Sign & Print Name) Date

Notary Public:

This Delegation of Consent must be notarized only if it is not signed and witnessed while at a TCP practice.

Sworn to before me this _____ day of _____20_____

_____ _____
Notary Public Date