PEDIATRIC AUTHORIZED REPRESENTATIVE FORM

I declare that I am the parent or guardian of the minor child ______________________, date of birth _____________. By signing below I declare that I am authorized to make all of the healthcare decisions for the child, and to receive all healthcare information for the child.

I hereby designate and appoint _________________________________ as an additional representative for the limited purpose of health care for my child, as authorized by this document.

In the event that I or another parent or guardian is unavailable or unable to make healthcare decisions for my child, and that no parent or guardian has given conflicting instructions, my representative has full authority to receive information and make preventative and/or treatment decisions regarding the above named child.

This consent for representation for health care of my child shall remain in effect for six (6) months unless revoked by me prior to the completion of the six (6) month period.

In the event that I or another parent or guardian is available to make healthcare decisions for my child, the instructions shall override any conflicting decisions made by my representative. Appointed child representative must present photo identification at each visit.

Parent/Guardian	Witness
_________________________________	_________________________________
_________________________________	_________________________________
Date: ___________________________	Date: ___________________________
Appointed Child Representative	Appointed Child Representative
_________________________________	_________________________________
_________________________________	_________________________________
Date: ___________________________	Date: ___________________________

Staff use only:
Photo identification obtained: ☐Yes ☐No Form of ID: _________________ Staff Initials: ______ Date: ___________