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**PROXY CONSENT TO TREAT MINORS**

**Purpose: This form may be used to allow an adult other than a parent to serve as a proxy decision-maker for routine medical care and services to be provided to a minor at Door County Medical Center.**

For some families, it may be more convenient to have prior authorization in place that allows routine medical/dental care to be delivered to minors under the care of a proxy decision-maker if a parent or legal guardian cannot be present to provide consent. If you would like to appoint a proxy decision- maker, please review and complete the following form authorizing a proxy decision-maker to consent to and authorize medical or dental treatment or services for and to be involved in the care of a minor child.

**AUTHORIZATION**:

I hereby appoint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name and Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

as a proxy decision-maker to consent to and authorize routine health care treatment and services for my child(ren) listed below.

*Routine medical/dental care and interventions may include, but are not limited to: medical evaluation, physical exam, x-rays, lab work (examples include: throat or nasal swabs, blood draws, urine catheterizations, dental cleanings, fluoride treatments, preventive and restorative dental treatments, wart treatment with liquid nitrogen, cleaning and trimming of minor burns, minor suturing of lacerations, removal of simple cysts, contraceptive care, and incision and drainage of abscesses). Door County Medical Center also may give immunizations, allergy shots or intramuscular/intravenous antibiotics pursuant to the consent of the proxy.*

I hereby empower and grant the proxy decision-maker appointed above permission to consent to and authorize routine medical or dental care as may be deemed necessary or advisable in the diagnosis and treatment of the minor child listed below and to receive protected health information directly relevant to, and for purposes of, his or her involvement in this care or payment related to this care. *(More than one child may be listed)*

Child’s Name: DOB:

Child’s Name: DOB:

**CHILD’S PROVIDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CHILD’S DENTIST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LIMITATIONS:**

Identify any specific limitations on the kinds of medical/dental services for which authorization is given (*if none, state “none”)*.

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**ALLERGIES/SIGNIFICANT MEDICAL CONDITIONS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENTAL CONTACT INFORMATION FOR QUESTIONS REGARDING TREATMENT:**

Parent’s Name: Parent’s Name:

Daytime Phone: Daytime Phone:

Evening Phone: Evening Phone:

Cell Phone: Cell Phone:

**INSURANCE INFORMATION**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby indemnify and hold harmless Door County Medical Center and all their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. The individual appointed as proxy (listed above) is permitted to make decisions or consent to the care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for one (1) year following the date signed below unless withdrawn in writing to Door County Medical Center or restricted by timeframe as noted above.

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Signature of Parent/Legal Guardian Date

*Minors Proxy Consent; Revised 7/13/18*