CASTLE ROCK
MEDICAL CENTER

CONSENT BY PROXY FOR PEDIATRIC CARE FORM

For families who are patients of Castle Rock Medical Center, 1400 Uinta Drive, Green River, WY 82935.

I (we) appoint____who is my (our) child(ren)'s
(Name/s)
____as my (our) proxy decision maker for consenting to
(specify nature of proxy's relationship to children)

acute medical care for my(our) children listed below. I (we) have the legal right to delegate such consent to the proxy decision maker, who is 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.

CHILDRENS NAMES

Name: ____DOB: ______________________

Name: ____DOB: ______________________

Name: ____DOB: ______________________

Name: ____DOB: ______________________

LIMITATIONS

Identify any limitations on the kinds of acute medical care services for which this consent by proxy is given. If none, state "none".

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Identify any limitations on the time frame for which this consent by proxy is given. If none, state "none".

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PARENT INFORMATION

I (we) have the legal right to delegate consent to treat to the proxy decision maker listed above, who is an adult and legally and medically competent to exercise the authority so delegated. I understand that protected patient health information may be shared with the proxy to facilitate informed decision making. I understand that this proxy can only accompany the child(ren) to acute care appointments. I understand legal guardians will be required to attend all other visit types for the minor child(ren).

Parents Name:_________________________ Parents Name:_________________________

Daytime Phone:_________________________ Daytime Phone:_________________________

Cell Phone:_________________________ Cell Phone:_________________________

_________________________ __________ _________________________ __________

Signature of Parent or Legal Guardian Date Signature of Parent or Legal Guardian Date