



Designation of Another Person to Consent for Minor Medical Care

If I, (parent/legal guardian) _____, cannot accompany my child,
(child's name) _____, to the Orchid Health Clinic, I give
permission to (person's name) _____ as follows (check one):

- ☐ I give permission for this person to seek medical treatment for my child (including any type of procedure) and provide consent for such treatment **without** having to contact me.
- ☐ I give permission for this person to seek medical treatment for my child (including any type of procedure) and provide consent for such treatment if attempts to contact me are unsuccessful.
- ☐ I give verbal permission to Orchid Health Staff for my child to seek medical treatment.

Witness name (printed)

Witness Signature

Date

Expiration of Permission (check one):

☐ This form will remain in effect until revoked (by filling out a "revoke consent form")

☐ This form is VALID ONLY during the following time frame:

Effective date: _____ / Expiration date: _____

X _____
(Signature of parent or legal guardian)

(Date required)

Home Phone _____

Work Phone _____