orchidhealth
Exceptional, local healthcare

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 _____