ALL★STAR PEDIATRICS

Alternate Caregiver Consent Form

I authorize the following individual(s) to bring my children to their appointments:

Name: _____ Relationship to children: _____

Name: _____ Relationship to children: _____

Name: _____ Relationship to children: _____

I attest that the above named individual(s) are all 18 years or age or older as of this date:

I authorize the individual(s) above to consent to treatment for my children named below. This may include, but is not limited to, consent for necessary medications, procedures, and hospitalization. I agree that All-Star Pediatrics may relay any medical information about my children necessary for the above named individual(s) to provide a full informed consent for treatment.

Well child visits and vaccinations will usually require that a parent or legal guardian be present.

I understand that the doctor will communicate the findings and treatment plan to the caregiver who brings the children, and that under most circumstances a follow-up call to me personally should not be necessary. I agree to be responsible for any fees for services requested by the above-named individual(s) when permitted by my insurance carrier(s).

I agree to hold All-Star Pediatrics and its staff harmless for any disagreement between the above-named individual(s) and me regarding treatment decisions.

I attest that I am the parent or legal guardian of the following children and that I have the legal authority to make this agreement. I understand that I can revoke this authorization for any or all of these individual(s) at any time.

Children covered by this consent:

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

_____ _____

Parent/Guardian Name Relationship to Child

_____ _____

Parent/Guardian signature Today's date