HAND IN HAND PEDIATRICS, INC.
6051 Memorial Drive, Dublin, OH 43017 Phone: 614-799-6044 Fax: 614-799-6088
114 Scott Farms Blvd., Marysville, OH 43040 Phone: 937-642-0535 Fax: 937-642-0872

Designation of Another Person to Consent for Treatment for Minor Child

I, (parent/legal guardian)____, cannot accompany my child, (child's name) ______________________________________, (child's date of birth) ___________________,to Hand In Hand Pediatrics. Therefore, I give permission to (person's name)_______________________________________

to consent to any necessary examination, medical diagnosis and/or medical care including, but not limited to, vaccines listed on the AAP's recommended vaccine schedule, to be rendered to the above named minor child under the general or special supervision and on the advice of any physician at Hand In Hand Pediatrics.

The above named person must bring your child's health insurance card and copay with them to the appointment. It is further agreed that if the parent or legal guardian wishes to discuss the medical care with the physician, a telephone consultation will be scheduled and the parent or legal guardian agrees to pay the cost of the telephone consultation at the time of the call. We do not bill insurance companies for telephone consultations; they are charged to and paid by the parent or legal guardian.

Expiration of Permission (check one):

☐ This form will remain in effect until revoked by written notice.

☐ This form is VALID ONLY during the following time frame:
Effective date: _________________ / Expiration date: _________________

____ ______________________
Signature of parent or legal guardian Date

____ ______________________
Signature of witness-MUST be 18 years or older Date

Medical History
List any known allergies, including medications:____
____

List any chronic existing diseases or medical problems (asthma, diabetes, epilepsy, etc.):______________
____

List any medications your child is taking now: ____
____