KU SCHOOL OF MEDICINE WICHITA MEDICAL PRACTICE ASSOCIATION The University of Kansas

Consent to Treat Minors

Purpose: This form may be used to allow an adult other than a parent to serve as a proxy decision maker for routine medical care and services at the KU Wichita Pediatrics at Valley Center – USD 262.

Authorization:

I hereby appoint _____ _____
Name Relationship

as a decision maker to consent to and authorize routine health care treatment and services for my child listed below.

☐ Check here if you authorize any adult, including a step-parent; accompany the child to be a decision maker who may consent to and authorize medical care, treatment or services for and to be involved in, the care of a minor child.

I understand routine medical care: treatment and services may include, but are not limited to: medical evaluation, physical exam, immunizations, x-rays, and lab work.

I hereby empower and grant the decision maker(s) appointed above, permission to consent to and authorize routine medical care as may be deemed necessary or advisable in the diagnosis and treatment of the minor child listed below and to receive protected health information (PHI) directly relevant to, and for purposes of, his or her involvement in this care or payment related to this care. *(Complete a separate form tor each child.)*

Child's Name: _____ **DOB:** _____

Parent's Name:	Parent's Name:
Daytime Phone:	Daytime Phone:
Evening Phone:	Evening Phone:
Cell Phone:	Cell Phone:

I understand there is no obligation to contact me if the decision maker consents to the care. The individual appointed as decision make herein is permitted to make decisions or consent to the care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for one (1) year following the date signed below unless withdrawn in writing to KU Wichita Pediatrics at Valley Center – USD 262. *(Only one parent's signature is required.)*

_____ _____
Signature of Parent or Legal Guardian Signature of Parent or Legal Guardian

Date: _____ Date: _____