CONSENT BY PROXY FOR NONURGENT PEDIATRIC CARE

FOR FAMILIES WHO ARE ONGOING PATIENTS OF:

PREMIER EYE CARE & SURGERY, LTD

I (we) appoint _____ (name) who lives at _____

_____ (address), who is

my (our) child(ren)'s_____ (specify nature of proxy's relationship to child(ren) as my (our) proxy decision maker for consenting to nonurgent medical care for my (our) child(ren) listed below).

I (we) have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. Be advised that protected patient health information may be shared with the proxy to facilitate informed decision making.

Name: _____DOB:_____
Name: _____DOB:_____
Name: _____DOB:_____
Name: _____DOB:_____

LIMITATIONS OF TREATMENT (choose one):

_____ I do not want to limit the type of treatment. I will let the ophthalmologist decide what treatment my child needs that day.

_____I want to limit the treatment. The ophthalmologist cannot:
_____
_____.

PLEASE CONTACT ME IF YOU HAVE QUESTIONS

I want you to call me if my child has a serious condition. If you are unable for any reason to contact me, the proxy may give consent.

Parent Name: _____ Parent Name: _____
Landline Phone: _____ Landline Phone: _____
Cell Phone: _____Cell Phone: _____

EXECUTED BY: _____ DATE: _____
Parent or Legal Guardian
EXECUTED BY: _____ DATE: _____
Parent or Legal Guardian

Proxy Decision Maker: _____

Driver's License Number of Proxy: _____