
# Proxy Consent for the Treatment of 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 CrossOver Healthcare Ministry clinics.**

For some families, it may be more convenient to have prior authorization in place that allows routine medical care to be delivered to minors under the care of a proxy decision maker if a parent or legal guardian cannot be present to provide consent. If you would like to appoint a proxy decision maker, please review and complete the following form authorizing a proxy decision maker to consent to and authorize medical treatment or services for and to be involved in the care of a minor child.

**AUTHORIZATION:**

I (We)_____ hereby appoint and authorize the following

Print name(s) of legal guardian(s)

individuals to bring my child(ren) in for evaluation and treatment of any acute or chronic medical condition, and for routine, well visit care. The individuals so named are adults over the age of 18. I authorize the following individuals listed below to provide informed consent on behalf of my minor child for any treatment or medications recommended or prescribed by my child's clinician including but not limited to routine vaccinations, allergy shots or intramuscular/intravenous antibiotics in accordance with guidelines and protocols. I authorize the following people listed below to receive released medical information on my minor child including, but not limited to laboratory or test results.

Name:_____ Phone:_____ Relationship_____

Name:_____ Phone:_____ Relationship_____

Further, I (We) authorize CrossOver Healthcare Ministry and its staff and volunteer personnel to deliver routine medical care to my child(ren), listed below. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, xrays, lab work (examples include: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, cleaning of minor burns, minor suturing of lacerations, removal of simple cysts, contraceptive care, and incision and drainage of abscesses).

If additional space is needed, please attach a separate sheet of paper.

*(Please Print)*

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

**LIMITATIONS:**

Identify any specific limitations on the kinds of medical services for which this authorization is given (If none, state "none")

_____

_____

Parental Contact information for questions regarding treatment:

Parent's Name:_____ Phone:_____ Relationship_____

Parent's Name:_____ Phone:_____ Relationship_____

I hereby indemnify and hold harmless CrossOver Healthcare Ministry, and all their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. The individual appointed as proxy (listed above) 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 year (1) following the date signed below unless withdrawn in writing to CrossOver Healthcare Ministry or restricted by time frame as noted above. *Only one parent's signature is required.*

_____ _____

**Signature of Parent/Legal Guardian** **Date**

_____ _____

**Signature of Parent/Legal Guardian** **Date**