DRS. BEDINGFIELD & ROSEWELL, S.C.
NORTHWEST CORPORATE CENTRE
2500 W. HIGGINS ROAD, SUITE 440
HOFFMAN ESTATES, IL 60169

Telephone: 847-839-0400
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CONSENT BY PROXY FOR NONURGENT PEDIATRIC CARE FORM
For families who are ongoing patients of Drs. Bedingfield & Rosewell.

I (we) appoint _____, who is my (our)
NAME
child(ren)'s _____ as my (our) proxy decision
(Specify nature of proxy's relationship to children)

maker for consenting to nonurgent medical care for my (our) children 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

Identify any limitations on the kinds of medical services for which this consent by proxy is given. If none, state "none."

_____

Identify any limitations on the time frame for which this consent by proxy is given. If none, state "none."

_____

CONTACT INFORMATION

PARENTS NAME: _____ PARENTS NAME: _____
DAYTIME PHONE: _____ DAYTIME PHONE: _____
EVENING PHONE: _____ EVENING PHONE: _____
CELL PHONE: _____ CELL PHONE: _____

IN WITNESS WHEREOF, the undersigned have executed this instrument as of the ___day of _____, 2____.

_____ _____
Parent or Legal Guardian Parent or Legal Guardian

_____ _____
Proxy Decision-Maker Driver's License Number of Proxy Decision-Maker