Non-Parental Authorization for Consent

Choptank Community Health System, Inc.
Non-Parental Authorization for Consent to Medical/Dental/Surgical Care and Treatment

I, ____, parent/legal guardian of the child(ren) listed below do hereby give my authorization and consent for the below named authorized person(s) to consent to the medical/dental/surgical care and treatment of my child(ren). I hereby authorize and grant that the below named person(s) has/have permission to sign for any medical/surgical procedures or treatments deemed necessary for the well-being of my child(ren). If the child(ren) presents with someone who is not listed on this form, every attempt will be made to contact the parent/legal guardian. I also understand it is my responsibility to notify CCHS of any changes to authorized persons.
*Well Child Checks will not be conducted without Parent(s) or legal guardian(s) present at time of office visit.
**This excludes patients seen in a CCHS School Based Health Center.

I am, by this document, representing that I have the authority to consent for all medical/dental/surgical care and treatment of said child(ren):

____________________________	____________________________	____________
Signature	Relationship to child(ren)	Date

Child(ren):

__________________________________	_____________________________
Name	Date of Birth
__________________________________	_____________________________
Name	Date of Birth
__________________________________	_____________________________
Name	Date of Birth
__________________________________	_____________________________
Name	Date of Birth

Person(s) who are authorized to get medical care for the child(ren) listed above:

_______________________________	_____________	_____________________
Name	Date of Birth	Relationship to Child(ren)
_______________________________	_____________	_____________________
Name	Date of Birth	Relationship to Child(ren)
_______________________________	_____________	_____________________
Name	Date of Birth	Relationship to Child(ren)

8/2/2017