Delegation of Consent

Name of Patient _____

Patient's Date of Birth _____

I hereby authorize (when I am unavailable to give consent) to the following individual(s):

_____ Name of person _____ Relationship to child/ Phone Number

_____ Name of person _____ Relationship to child/ Phone Number

_____ Name of person _____ Relationship to child/ Phone Number

_____ Name of person _____ Relationship to child/ Phone Number

to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the state of Texas. This consent includes, but is not limited to, medical and surgical intervention and elective as well as emergency care.

This delegation shall be valid until I withdraw delegation of consent.

Signature of Parent/Guardian/Patient (if 18 years or older) _____

Relationship to Patient _____

Date _____

Witness _____