<u>Delegation of Consent</u>

Name of Patient: ____________________________________ DOB: _____________
(Date of Birth)

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

______________________________	___________________________
Name of Person	Relationship to Child
______________________________	___________________________
Name of Person	Relationship to Child
______________________________	___________________________
Name of Person	Relationship to Child
______________________________	___________________________
Name of Person	Relationship to Child

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 New York. 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)	Relation to Patient	Date

___________________________________	___________________________________
Witness	Translator/Reader (if applicable)