Alternate Care Giver Form

Post Road Pediatrics
Boston Children's
Primary Care Alliance

postroadpediatrics.com
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I authorize the following individual(s) to bring my children to their appointments:

Name: _____

Relationship to child: _____

Name: _____

Relationship to child: _____

Name: _____

Relationship to child: _____

Name: _____

Relationship to child: _____

I attest that the above named individuals are all 18 years of age or older as of this date.

I authorize the above named individual(s) to consent to treatment for my children. This may include, but is not limited to, consent for necessary medications, vaccinations, procedures, and hospitalization. Post Road Pediatrics, LLP may relay any medical information about my child necessary for the above named individual(s) to provide informed consent to the treatment.

I understand that the doctor will communicate his or her findings and treatment plan to the caregiver who brings the child, and that under most circumstances a follow-up call to me personally should not be necessary.

I agree to hold Post Road Pediatrics, LLP and its staff harmless for any disagreement between the above named individuals and myself regarding treatment decisions.

I attest that I am the parent or legal guardian of the following children and that I have the legal authority to make this agreement. I understand that I can revoke this authorization for any or all of these individuals at any time.

Children covered by this consent:

Child 1 name: _____

Date of birth: _____

Child 2 name: _____

Date of birth: _____

Child 3 name: _____

Date of birth: _____

Child 4 name: _____

Date of birth: _____

Child 5 name: _____

Date of birth: _____

Parent/guardian's name: _____

Signature: _____

Date: _____

10/11/11