Rev. 11/2023

Peter Christensen Health Center

Delegation of Parental Power to Authorize Medical Care/Treatment for Minor Child in Absence of Parent/Legal Guardian

To comply with Wisconsin law, Peter Christensen Health Center requires that a parent having legal custody of a minor child, or a legal guardian (guardian of the child's person, appointed by a court), consent to medical care and treatment for the minor child. The parent or parents having legal custody of a minor child or the legal guardian of a minor child may delegate the parental power to consent to medical care and treatment for the child to another adult, in the event the said parent or guardian is unavailable to consent. If the minor child presents for a non-urgent medical/mental health appointment without a parent or legal guardian or a signed consent, treatment may be denied.

Name of Minor Child_____ **DOB:**_____

I,_____,
NAME(S) OF PARENT(S) OR GUARDIAN

state that I/we have legal custody of the child named above. **(Only a parent who has legal custody or the guardian of a child's person may use this form.)** A parent **may not** use this form to delegate parental powers regarding a child who is subject to the jurisdiction of the juvenile court under s. 48.13, 48.14, 938.12, 938.13, or 938.14, Wis. Stats. or like Tribal Ordinance.

I/We, the undersigned parent(s) or legal guardian of the above-named minor child, authorize the following Agent to make medical care decisions for the above-named minor child in my/our absence, consent to medical care and treatment of and for the minor child in my/our absence, and have access to the child's Protected Health Information:

Name of Agent:_____ Relationship to Child:_____

Agent's Address _____

Agent's Phone Number(s)_____

Agent's Email Address and Additional Contacts _____

If applicable:
Additional Name of Agent:_____ Relationship to Child:_____

Agent's Address _____

Agent's Phone Number(s)_____

Agent's Email Address and Additional Contacts _____

Additional Name of Agent:_____ Relationship to Child:_____

Agent's Address _____

Agent's Phone Number(s)_____

Agent's Email Address and Additional Contacts _____

Delegated Agents will be required to show proof of identification when bringing a minor in for treatment/services.

I/we specifically authorize the above-named Agent to have access to such of the above-named child's Protected Health Information as may be necessary to enable the Agent to make informed health care decisions for the child, and delegate to the above-named Agent the power to consent to the following health care for the above-named minor child in my/our absence:

☐ **The power to consent to ALL health care; OR**

☐ **The power to consent to only the following health care:**

☐ **Ordinary or routine health care, excluding major surgical procedures, extraordinary procedures, and experimental treatment**

☐ **Emergency Care, incl. Blood Transfusions**

☐ **Mental Health Treatment**

☐ **Immunizations**

☐ **Lab Work**

☐ **Diagnostic Tests (X-ray, MRI)**

☐ **Other_____**

☐ **Chiropractic Services**

☐ **Physical Therapy/Occupational Therapy**

☐ **Physicals (school, pre op)**

☐ **Annual Exams**

☐ **Oral Surgery Treatment**

☐ I/we, the undersigned request that Peter Christensen Health Center attempt to contact me/us prior to providing health care to the above-named minor child. However, it is not necessary that I/we be contacted prior to the provision of health care to the said child, provided consent is obtained from the Agent named above. Peter Christensen Health Center is authorized to rely fully upon the delegation of parental power set forth herein.

EFFECTIVE DATE AND TERM OF THIS DELEGATION

This Delegation of Power will remain in effect for a **period of one (1) year** after the effective date. **A new Delegation of Power must be completed if the parent/legal guardian wishes for the timeframe to renew/extend for another year.**

REVOCATION OF THIS DELEGATION

This Delegation of Power may be revoked in writing at any time by the guardian of the child's person or by a parent who has legal custody of the above-named child, and such a revocation invalidates the delegation of parental powers made herein, except with respect to acts already taken in reliance on this Delegation of Power.

SIGNATURE(S) OF PARENT(S) OR GUARDIAN

_____ _____

Mother's Signature Date

_____

Address

_____ _____ _____

Home Phone Cell Phone Email Address

_____ _____

Father's Signature Date

_____

Address

_____ _____ _____

Home Phone Cell Phone Email Address

_____ _____

Guardian's Signature Date

_____

Address

_____ _____ _____

Home Phone Cell Phone Email Address