Children's Hospital
New Orleans
LCMC Health

DELEGATION OF CONSENTING AUTHORITY

PATIENT INFORMATION

PLACE PATIENT'S LABEL HERE

Date:_____ MRN:_____

I, _____ authorize the following individuals to consent for medical treatment including, but not limited, to vaccination by physician(s) for my child(ren):

Child's Name (please print)	Date of birth

The consent given by the authorized designee shall be valid and binding as would the consent given by the parent and the physicians can rely on this authorization and accept any consent given by the authorized designee until such time as physician receives written notice that the authorization is revoked.

AUTHORIZED DESIGNEE(S)

Name:	Relationship to Patient
Name:	Relationship to Patient

Parent or Legal Guardian's Signature:	Date MM/DD/YY	Time 00:00 AM/PM
X	/ /	:
Relationship to patient:		