



Alternate Caregiver Consent Form

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: _____

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

I authorize the above named individuals(s) to consent to treatment for my children. This may include, but is not limited to, consent for necessary medications, immunizations, procedures, and hospitalization. Riverview Pediatrics may relay any medical information, including protected health information, about my child that is necessary for the above named individual(s) to provide informed consent.

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 us should not be necessary. I agree to be responsible for any fees for service requested by the above named individual(s) when permitted by my insurance carrier(s).

I agree to hold Riverview Pediatrics 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 (list full names and dates of birth)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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We Care About The Little Things...



Alternate Caregiver Consent Form

Riverview Pediatrics must receive permission from a minor's parent or legal guardian before providing treatments for an injury or illness that is non-life threatening (consent to treat is generally implied in emergency situations). This form gives us legal permission to treat your child in case you cannot accompany him/her to Riverview Pediatrics for treatment. If the person accompanying your child (babysitter, friend, relative, etc.) does not present this information, Riverview Pediatrics will attempt to contact you to request permission to treat your child.

PLEASE NOTE:

- A parent or legal guardian **must** attend a minor's **first visit** at Riverview Pediatrics.
- A parent or legal guardian **must** attend a minor's well child checkup/yearly physical/school physical or sports physical
- Minors may receive immunizations only with **a parent or legal guardian's consent**.
- A parent or legal guardian must provide this form directly to the minor's provider, in person, before the effective date of this form.
- This "Alternate Caregiver Consent Form" is only effective for the time frame listed below.
- In certain circumstances, in accordance with State and Federal laws, parent/guardian permission may not be needed for adolescents being treated for concerns deemed as "heightened sensitivity," including but not limited to STD testing, family planning, mental health, etc.

In case of an emergency, I can be reached at:

Name: _____

Best Phone Number: _____ Alternate Phone Number: _____

Name & Signature of Parent/ Guardian: _____

Copy of ID of parent/guardian on file: Y or N _____ Date: _____

RVP Witness: _____ Date: _____

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