Keystone Health

If label not available, please fill in below:
NAME: _____
DOB: _____
MRN: _____

Delegation of Consent to Treatment of an Unemancipated Minor/Incapacitated Adult

I, _____,
(First) (Middle) (Last)

I am,

- ☐ Parent of the child listed below. No court orders now in effect would prohibit me from giving this consent. The child, if aged 14 or older, did not directly consent to treatment.
- ☐ Legal guardian or legal custodian of the child by court order (copy attached, if available). No court orders now in effect would prohibit me from giving this consent. The child, if aged 14 or older, did not directly consent to treatment.
- ☐ A Healthcare Representative Declaration was provided to me and signed.

I give the following person(s) the power to consent to necessary medical, dental, or mental health treatment of (name of patient): _____,
(First) (Middle) (Last)
date of birth _____ when I am not reasonably available to provide consent.

#1	#2
Name of adult: _____	Name of adult: _____
Signature: _____	Signature: _____
Relationship: _____	Relationship: _____
The person named above may consent to the patient's examination and/or treatment, specified below, when I am not reasonably available to do so:	The person named above may consent to the patient's examination and/or treatment, specified below, when I am not reasonably available to do so:
☐ Medical ☐ Dental ☐ Surgical ☐ Immunizations	☐ Medical ☐ Dental ☐ Surgical ☐ Immunizations
☐ Developmental and/or mental health	☐ Developmental and/or mental health
I agree that the above-named adult:	I agree that the above-named adult:
☐ May go into the room with the patient.	☐ May go into the room with the patient.
☐ May not go into the room with the patient.	☐ May not go into the room with the patient.

This form is in effect until the earliest of (1)the minor reaches 18 years of age or is emancipated; (2) consent to treatment is withdrawn; or (3) this Delegation of Consent to Treatment is revoked by me in writing.

_____ _____ _____
Parent/Guardian Signature Printed Name Date

**********Office Use Only**********

Received by:_____ Date:_____ Site:_____

Completed by:_____ Date:_____

4/4/23ksw