The Youth Clinic
caring for our future generations

Pediatric Urgent Care
OF NORTHERN COLORADO

PEDIATRIC CONSENT TO TREAT BY PROXY FORM

Patient Information
Full Name of Minor: _____
Date of Birth: _____
Address: _____

Parent/Legal Guardian Information
Full Name: _____
Relationship to Minor: _____
Contact Number(s): _____

Authorized Adult (Proxy) Information
Full Name: _____
Relationship to Minor: _____
Phone Number: _____

Authorization Statement
I, the undersigned parent/legal guardian, authorize the above-named adult to:
- Accompany my child to medical appointments
- Consent to non-emergent, routine medical care (e.g., physical exams)
- Receive medical information regarding my child's visit

This authorization is granted pursuant to Colorado Revised Statutes § 15-14-105 (which states a parent or guardian of a minor or incapacitated person, by a power of attorney, may delegate to another person, for a period not exceeding twelve months, any power regarding care, custody, or property of the minor).

Limitations or Restrictions (if any):
_____

Effective Dates
Start Date: _____
End Date: _____
☐ Authorization is ongoing until revoked

Emergency Contact Preference
☐ I wish to be contacted for any additional, unanticipated medical services
☐ I do not wish to be contacted unless medically necessary

Signature
Parent/Legal Guardian Signature: _____Date:_____