AMERICAN ACADEMY OF PEDIATRICS

CLINICAL REPORT

Guidance for the Clinician in Rendering Pediatric Care

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Consent by Proxy for Nonurgent Pediatric Care

ABSTRACT. Minor-aged patients are often brought to the pediatrician for nonurgent acute medical care or health supervision visits by someone other than their custodial parent or guardian. These surrogates can be members of the child's extended family, such as a grandparent or aunt. In cases of divorce and remarriage, a noncustodial parent or stepparent may accompany the patient. Sometimes, children are brought for care by adults living in the home who are not biologically or legally related to the child. In some instances, a child care professional (eg, au pair, nanny) brings the pediatric patient for medical care. This report identifies common situations in which pediatricians may encounter "consent by proxy" for nonurgent medical care for minors and explains the potential for liability exposure associated with these circumstances. The report suggests practical steps that balance the need to minimize the physician's liability exposure with the patient's access to health care. Key issues to be considered when creating or updating office policies for obtaining and documenting consent by proxy are offered.

ABBREVIATIONS. AAP, American Academy of Pediatrics; VICP, Vaccine Injury Compensation Program; VIS, vaccine information statement.

BACKGROUND INFORMATION

Before providing nonurgent medical care to a minor patient not accompanied by a custodial parent or legal guardian, important questions regarding informed consent and the delegation of parental responsibilities need to be asked and answered. These include:

1. Who has a legal right to delegate consent to health care decisions for a child?
2. To whom can the power to consent to health care for a child be delegated?
3. In what circumstances can the power to consent to health care for a child be delegated?
4. What are the limitations on the right to delegate the power to consent to health care for a child?
5. How is authorization of proxy consent verified and documented?
6. When or how often does information on proxy consent need to be updated?

Many aspects of informed consent in pediatrics have been set forth in previous policy statements from the American Academy of Pediatrics (AAP). Some of these statements address informed consent in broad terms and others address narrowly focused situations. The AAP Committee on Bioethics statement on informed consent[1] notes that, unlike in other specialities, "the doctrine of 'informed consent' has limited *direct* application in pediatrics." The statement explains that parents or other surrogates provide *informed permission* for diagnosis and treatment of children. It describes a continuum of consent, which gradually shifts the accessibility to health information, communication of treatment options, and decision making from parent or guardian alone, to parent or guardian with child's assent, to informed consent by the patient. Other AAP policy statements provide guidance to pediatricians on consent for treatment of minor patients in specific circumstances, such as emergency care,[2] reproductive issues for adolescence,[3,4] genetic testing and newborn screening,[5] procedures involving sedation,[6] and parental denial of medical care for religious reasons.[7]

This report does not replace any previous policy statements; they stand on their own merit. Instead, this report addresses the liability risks physicians incur when providing nonurgent medical care to pediatric patients without obtaining permission or consent from the patients' legal representative. It also addresses the medicolegal implications for pediatricians when custodial parents or legal guardians delegate the authority to consent to nonurgent medical care for their minor children to other adults. Suggestions are offered to help pediatricians minimize their exposure to legal risk in these situations. Pediatricians are advised to use their good judgment in balancing the patient's health care needs with their own need for legal protection. Because pediatricians are primarily concerned with their patients' welfare, discretion must be used to identify situations in which care can be delayed pending appropriate parental consent and situations in which the pediatrician should provide care and accept the risk of legal repercussions. Careful planning and good office policies can minimize those instances.

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

LEGAL REALITIES

Except for situations in which a minor's right to consent to care has been legally established, in general, persons who have not yet reached the age of majority do not have the right to consent to their own medical care. In most states, the age of majority is 18 years. Thus, in general, the law requires the physician to obtain consent from a parent or legal guardian before performing a medical or surgical test, procedure, or treatment on a minor.[8] However, case law and legislative action have resulted in several exceptions to the parental consent requirement (eg, emergency treatment; treatment of an emancipated minor; treatment for sexual assault, sexually transmitted diseases, drug abuse, and alcohol dependency). Some states attempt to balance the rights of the minor and the parent by requiring parental notification for medical tests or treatments consented by minors.

A physician who provides nonurgent care to a patient without the consent of that person or someone legally authorized to speak for the individual may be vulnerable to legal action. Lawsuits that allege a lack of informed consent usually are based on the concept of negligence but may involve battery as well.[9] In general, battery is the unsolicited physical touching of a person.[10] The physician may face a battery claim although the treatment or procedure is performed without any negligence.[11] Particularly when a plaintiff is not satisfied with the results of the medical treatment or procedure but is unable to prove negligence in litigation against the physician, the plaintiff may resort to the theory of battery to seek a recovery. If the plaintiff alleging an unauthorized procedure cannot prove actual harm, typically only nominal damages will be recovered. However, in certain circumstances, punitive damages may be assessed, which may not be covered by malpractice insurance or dischargeable by bankruptcy.

DEFINITION OF TERMS

Nonurgent Pediatric Care

For the purposes of this clinical report, nonurgent pediatric care is defined as preventive medicine (ie, services encompassed in pediatric health supervision visits including immunizations, screening tests) and outpatient medical encounters for minor illnesses or injuries.

Informed Consent

Informed consent is a general principle of law that imposes on physicians a duty to disclose to their patients the benefits and risks associated with each of the following: 1) the proposed course of treatment; 2) alternative treatments; and 3) no treatment at all. In general, informed consent is meant to allow patients exercising ordinary care for their own welfare to exercise judgment in consenting to medical interventions by reasonably balancing the probable risks against the probable benefits.[12] State standards to determine the adequacy of disclosure under informed consent can be physician based (ie, benefits and risks that a "reasonable" physician would disclose), patient based (ie, benefits and risks that a "reasonable" patient would want to know), or a hybrid of both (Table 1). Legal requirements for informed consent may also be specific to medical procedures or tests (Table 2).[13]

Consent by Proxy

The process by which people delegate to another person the legal right to consent to medical treatment for themselves, for a minor, or for a ward is called consent by proxy. There are 3 fundamental con-

TABLE 1. State Standards to Determine Adequacy of Disclosure

State	Physician Based	Patient Based	Hybrid
Alabama	X		
Alaska		X	
Arizona	X		
Arkansas	X		
California		X	
Colorado			X
Connecticut		X	
Delaware	X		
District of Columbia		X	
Florida			X
Georgia		X	
Hawaii			X
Idaho	X		
Illinois	X		
Indiana	X		
Iowa		X	
Kansas	X		
Kentucky			X
Louisiana		X	
Maine	X		
Maryland		X	
Massachusetts		X	
Michigan	X		
Minnesota		X	
Mississippi		X	
Missouri	X		
Montana	X		
Nebraska	X		
Nevada	X		
New Hampshire	X		
New Jersey		X	
New Mexico		X	
New York	X		
North Carolina	X		
North Dakota			X
Ohio		X	
Oklahoma		X	
Oregon			X
Pennsylvania		X	
Rhode Island		X	
South Carolina	X		
South Dakota		X	
Tennessee	X		
Texas			X
Utah			X
Vermont	X		
Virginia	X		
Washington		X	
West Virginia		X	
Wisconsin		X	
Wyoming	X		

This table attempts to summarize various federal and state laws into general categories for educational purposes. It is not intended as a substitute for legal advice.

Reprinted with permission from American Medical Association. *Medicolegal Forms with Legal Analysis: Documenting Issues in the Patient-Physician Relationship.* Kinderman K, ed. Chicago, IL: American Medical Association; 1999:121

TABLE 2. Federal and State Survey of Informed Consent Provisions

Location	Medical Treatment						Medical Testing					
	In General	Immunizations	Abortion-Minor	Drug/Alcohol	Electroconvulsive/Electroshock	Emergency	AIDS/HIV	Blood Testing for AIDS/HIV	Blood Testing and Vehicle Operation	Contagious Disease	Experiment/Research	Genetic
Federal				X		X			X		X	
Alabama		**	X			X	X				X	
Alaska	X	X	X	X	X	X						
Arizona		*	X			X	X	X			X	X
Arkansas		*		X		X	X		X			
California		X	X	X	X	X	X	X	X	X	X	X
Colorado	R	X		X	X	X	X	X	X			
Connecticut				X	X	X	X	X	X			
Delaware	X	X		X		X	X		X	X	X	
District of Columbia		X									X	
Florida	X	X		X	X	X	X	X	X		X	X
Georgia	X	X	X	X		X			X			X
Hawaii	X	X				X	X					
Idaho	X	**		X	X	X		X				
Illinois		X	X	X	X	X	X				X	
Indiana	X	X	X			X	X				X	
Iowa	X	X	X			X	X					
Kansas		X		X	X						X	X
Kentucky	X	X	X		X	X	X					
Louisiana	X		X		X		X	X				
Maine	X		X			X	X					
Maryland		X	X	X		X	X	X				
Massachusetts		**		X		X						
Michigan		X	X		X	X	X					
Minnesota				X	X	X						
Mississippi		X				X	X					
Missouri		X	X		X						X	
Montana		X		X		X	X				X	
Nebraska	X	X				X	X			X		
Nevada	X	X		X								
New Hampshire		X		X	X	X	X	X			X	X
New Jersey		X		X	X						X	
New Mexico		X				X						
New York	X	X		X	X	X					X	X
North Carolina	X	**	X		X	X	X				X	
North Dakota		**	X		X		X	X		X		
Ohio	X	X	X			X	X					
Oklahoma		X		X		X					X	
Oregon	X	**					X	X				
Pennsylvania	X	X			X	X	X	X				
Rhode Island		X	X	X		X	X	X				
South Carolina			X		X	X						
South Dakota		**			X							
Tennessee		X	X	X		X	X				X	
Texas	X	X		X	X	X	X					X
Utah	X	X		X	X	X						
Vermont	X	X		X		X	X					X
Virginia		X			N		X				X	
Washington	X	X		X	X		X					
West Virginia		X					X	X				
Wisconsin	X	X	X	X	X	X	X					
Wyoming		X	X									

X = informed consent required by law, R = requirement repealed, * = unemancipated minor may consent; ** = age at which minors may self-consent for immunization services is 15 years and under; N = no requirement.

This table attempts to summarize various federal and state laws into general categories for educational purposes. It is not intended as a substitute for legal advice.

Sources: Gordon T, Zook E, Averhoff F, Williams W. Consent for adolescent vaccination: issues and current practices. *J Sch Health.* 1997;67:259–264; and American Medical Association. *Medicolegal Forms with Legal Analysis: Documenting Issues in the Patient-Physician Relationship.* Kinderman K, ed. Chicago, IL: American Medical Association; 1999:109–110

straints on this right to delegate for children: 1) the guardian of a minor must have the right to consent to medical treatment for that minor; 2) the guardian must be legally and medically competent to delegate the right to consent to medical treatment for that child; and 3) the right to consent to medical treatment for the child must be delegated to a legally and medically competent adult.[14]

Minor

A person who is younger than the age of legal competence is a minor by definition. The term is derived from the civil law. In most states, a person is no longer a minor after reaching 18 years of age, although state laws might still prohibit certain acts until reaching an older age (eg, purchase and consumption of alcohol).[12]

Delegation of Parental Authority

Because there is no legal requirement to provide nonemergency pediatric care to a minor without the consent of a parent or legal guardian in person or in writing, pediatricians who choose to treat such patients may unwittingly be assuming additional risk of exposure to liability. According to a 1999 periodic survey of AAP fellows, "Pediatricians' Experiences With Child Care Health and Safety,"[15] many pediatricians have not adopted policies to minimize these risks. The survey found that 1 in 4 pediatricians treats patients brought in by child care providers only if they have authority from the parents. One third of respondents have no set policy regarding treating patients brought in for nonemergency acute care or preventive visits by child care providers. Less than 6% of pediatricians report that they prefer not to treat patients brought in by child care providers. However, if such occurrences are anticipated, the custodial parent or legal guardian may delegate to another competent adult the right to consent to medical care for a child. Physicians may encourage parents or legal guardians to identify persons who may consent to their child's care if they are not available. As with all other delegations of authority to consent to medical care, the person to whom the authority to consent is delegated must be a competent adult.

FAMILY LIVING ARRANGEMENTS

Changes in family living arrangements and use of child care are leading reasons why someone other than a custodial parent or guardian may bring a minor patient in for nonurgent ambulatory pediatric care. The US Census Bureau describes many aspects of family living arrangements.[16] Of the more than 70.2 million children younger than 18 years in the United States, 71% spend most of their childhood living in 2-parent families. However, a significant proportion of children reside in homes with other family configurations. One child in 4 lives with a single parent, most often a single mother. Many single parents have cohabiting partners, including 9% of single mothers and 16% of single fathers. Thus, 3.3 million children (5% of all children) live with a parent or parents who cohabit. More than 17 million children are being raised in homes headed by a single parent, and more than 4 million children live with a biological parent and a stepparent who may not have legal rights. This means that one third of all children in the United States do not have 2 parents in the home with legal authority to consent to medical treatment and, thus, may be brought to the pediatric office for nonemergency care by an adult who may not have authority to consent for that child's medical care.

CHILD CARE

Census reports confirm that an increasing proportion of children spend substantial amounts of time in the care of a person other than their parents.[16] In 2000, 61% of children from birth through third grade received some form of child care on a regular basis from persons other than their parents. This translates to close to 12 million children. Younger children (birth to 2 years of age) are more likely to be in home-based care than center-based care.

DOCUMENTING CONSENT BY PROXY

With so many variations in family living arrangements and so many parents in the workforce, it is fairly common for someone other than the child's custodial parent or legal guardian to accompany a child to the pediatrician's office. Although this affords an opportunity to assess the relationship between the child and the caregiver, it precludes face-to-face contact between the pediatrician and the parent. If it has been anticipated that a caregiver other than a child's parent or legal guardian may bring the child to pediatric visits, arrangements should be made for the custodial parent or legal guardian to provide a written consent by proxy. In general, these documents specify the name of the custodial parent or legal guardian, the name of person to whom the parent's legal authority to consent to the child's medical care has been delegated, and the relationship of that person to the child. Such documentation may need to delineate the extent of the surrogate's authorization (ie, the circumstances, the kinds of medical services, or the specified time period for which the surrogate may provide consent for medical care). Authorized signatures may be required, and state law may require that signatures be notarized.

The surrogate or proxy relationship should be verified and documented periodically. The patient's medical record should be flagged to alert the pediatrician and nursing staff of situations in which the caregiver cannot provide consent. If the pediatrician has any doubts about the caregiver's capability to provide permission for medical care (eg, lack of maturity, presence of intoxication, unclear legal standing, or the inability to understand risk communication—perhaps because of language barriers), then the pediatrician may need to consider deferring elective care until parental permission can be obtained.

If the pediatrician is uncomfortable with consent by proxy arrangements, this needs to be communicated with parents up front. The topic could be broached during early discussions of child care arrangements at prenatal or newborn visits or ad-

dressed during medical encounters before the parent returns to employment outside the home. Typically, the pediatrician explains the importance of the "therapeutic alliance"[17] between the pediatrician, parent, and patient and emphasizes why it is preferable for at least 1 parent to be present during preventive and acute care visits. Offering extended office hours (evenings or weekends) is another way pediatricians have made it possible for working parents to attend their children's medical appointments.

UNACCOMPANIED TRAVEL

Consent by proxy forms can be useful in other situations as well. Children who travel without their parents or legal representatives sometimes require medical treatment for a minor injury or illness. This often occurs when children who are too young to consent to their own care are visiting friends or relatives without their parents. Although most parents will sign a proxy consent form when their children go to school or summer camp, few parents think about sending a signed proxy consent form along when their children leave home for an extended period (eg, a week visiting grandparents). Depending on state law, a child may not be able to obtain routine medical care without consent to such care by an authorized adult. Pediatricians may encourage parents to anticipate these problems and take steps necessary to ensure that their children traveling without a custodial parent or legal guardian can receive needed nonurgent medical care.

CUSTODY AND CONSENT

In most states, parents who are married to each other have an equal right to consent to medical care for the children of that marriage, and the consent of only 1 parent is required for nonurgent pediatric care in such cases. Even in cases in which the parents are divorced or were never married, ordinarily the consent of only 1 parent is sufficient to proceed with routine nonurgent medical treatment. However, some states limit the rights of noncustodial parents and fathers of children born out of wedlock to provide consent to medical care for their children.

One of the most difficult situations for securing parental consent for a child's health care occurs when children are used as pawns in marital conflict. Disputing parents can use situations for deciding whether the child should receive nonurgent medical care (eg, health supervision visits, immunizations, and minor procedures) as an opportunity to spar over parental rights. As mentioned previously, generally if both parents have equal right to consent to care for their child, the physician need only obtain consent from 1 parent to provide that care. However, if consent has been refused by 1 parent, it is not clear whether the pediatrician may seek consent from the other parent.[14]

The pediatrician should clarify who has the right to medical information and should specifically ask about any joint physical or legal custody agreements.[18] Joint legal custody may be relevant to coordinating medical care, because some joint custody agreements require that both parents may need to give consent and be informed about their child's medical needs. In such cases, joint physical custody necessitates an often fairly complex schedule and close coordination between parents.

Less commonly recognized is the problem of children visiting a noncustodial parent in another state, especially if that state's law does not permit a noncustodial parent to give permission for his or her child to receive medical care. These situations are usually unexpected but not unmanageable. For instance, a pediatrician may be puzzled when a family associated with the practice seeks medical care for a child never mentioned or seen previously. It may be a child or stepchild from a previous marriage or relationship who lives in another state and who, while visiting the family, becomes ill and needs medical attention. In such situations, pediatricians need to make sure that the adult with the child has the authority to consent to the medical care before treating. It is suggested that office staff document the name and relationship of the person providing permission and how his or her authority to do so was ascertained.

OTHER CIRCUMSTANCES

Four percent of all US children do not live with either of their biological parents.[16] They may be in foster care, under the care of a relative, with a potential adoptive parent, or in other situations in which their caregiver is not a biological parent. If the child has a legally appointed guardian, the guardian must consent to the child's medical care in the same fashion as for an adult ward. The pediatrician should ascertain the exact nature of the relationship, verify the authority of the surrogate, and document the legal basis of the surrogate-child relationship and the exercise of the informed consent process within that context.

In some cases, no one has asked the court to appoint a guardian for the child. These children are in legal limbo; no one may consent to their care, but it is unthinkable to deny them necessary care because of their legal status. A child should be treated as necessary while steps are taken to have the caregiver appointed as temporary guardian for the child. If the child is in need of simple elective care, the pediatrician should use his or her best judgment in deciding whether to postpone providing the care until a guardian can be appointed or render the care and document the relevant circumstances. For these and other obvious reasons, pediatricians should notify child protective services when a child needs a legal guardian.[14]

IMMUNIZATIONS

Although some would debate the logic of requiring informed consent for state-mandated services, such as immunizations, it is clear that open dialogue about risk is at the heart of the national Vaccine Injury Compensation Program (VICP).[19] Vaccine information statements (VISs) were created to meet the informational requirements of the VICP; however, VISs alone are not considered informed consent. Under the VICP, providers must distribute a VIS to the

patient's legal representative every time a covered immunization is administered. The law defines legal representative as a parent or other individual who is qualified under state law to consent to the immunization of a minor. Therefore, pediatricians must know what the state law requires for informed consent related to immunization of minors. Parental consent for immunizations is standard practice in 43 states.[20] These state laws may cover procedural requirements (eg, whether consent may be oral or must be written) or substantive requirements (eg, types of information required). Most states require separate consent for each injection when more than 1 is required to complete immunization. Most states require consent for immunization services provided to adolescents. Nine states allow adolescents to self-consent for hepatitis B immunization in clinics specializing in sexually transmitted disease and family planning as part of the exemption for minors' receipt of sexual health services. Unless the law provides otherwise, immunizations should not be given without appropriate consent from a parent or legal guardian.

VISs explain the benefits and risks associated with each childhood immunization. However, VISs are intended to facilitate, not replace, effective risk communication between the health care professional and the patient's legal representative. Guidelines on the distribution of VISs and documentation of vaccine administration are available in a booklet published by the Department of Health and Human Services, "What You Need to Know About Vaccine Information Statements"[21] or by accessing the Centers for Disease Control and Prevention Web site (http://www.cdc.gov/nip/publications/VIS/default.htm). These instructions also are summarized in the AAP 2003 *Red Book*.[22] In addition, the AAP produces vaccine administration record forms to help pediatricians comply with the VICP documentation requirements. For non–English-speaking patients, VISs have been translated into more than 20 languages. These can be accessed and downloaded from the Immunization Action Coalition Web site (http://www.immunize.org/vis/).[23]

LANGUAGE BARRIERS TO INFORMED CONSENT BY PROXY

If the person to whom the parents or guardians have delegated the right to consent to their child's medical care does not speak the same language as the pediatrician, it may be difficult to obtain informed consent. Although patient education materials and consent forms can be developed in various languages for common procedures requiring informed consent, it would be unwise to rely exclusively on written informed consent methods. Regional differences in language can affect the meaning of medical terminology. Translations that are accurate according to the language textbook may not be appropriate to the comprehension level of the reader.

If the pediatrician suspects that language barriers may compromise the communication between him or her and the surrogate necessary for informed consent, other steps may need to be taken. Healthcare professionals participating in federal health programs (eg, Medicaid, State Children's Health Insurance Program, TriCare, Medicare) must meet requirements for accommodating patients with limited English proficiency, which involve qualified translators other than family members.[24] It is preferable to have someone who is medically knowledgeable explain the illness, treatment options, and known risks and benefits in the caregiver's own language. If a translator is used, it is important to identify that person in the patient's medical record. The practice should record and retain the name, address, and background of the translator retained on file. Translators should be instructed that they are to communicate the caregiver's answer directly. This is vital in conveying to the pediatrician whether the respondent's answer indicates an understanding of the elements needed for informed consent and whether an agreement has been reached as to the medical treatment. It is not advisable to use children (eg, the patient or an older sibling or relative) as translators for informed consent discussions between the pediatrician and the child's legal representative.

SUMMARY

Situations involving consent by proxy can occur for a variety of reasons. Pediatric practices need to anticipate these occurrences and develop policies that promote good, informed decision making and risk management. Care should be taken to make sure that such policies meet applicable laws without blocking access to necessary but nonurgent health care. Pediatricians have sought ways to accommodate the diverse living and working arrangements of their patients' families. Many pediatricians are working parents themselves and know well the challenges of family life. Developing a legally sound office policy on consent by proxy is essential to maintaining smooth office operations and strong physician-patient relationships.

IMPLEMENTATION SUGGESTIONS

1. Determine whether the practice will see minor patients without a custodial parent or guardian present. It is usually best if all physicians within the practice adopt the same policy; otherwise, problems can arise during coverage situations.
2. If the practice's decision is not to provide nonurgent care to patients without a custodial parent or legal guardian present, then the policy for the office and an information sheet explaining this should be provided to patients. The policy should also be made clear during contacts with new or prospective patients. As always, it is advisable to have legal counsel review the office policy and supporting documents to ensure compliance with applicable laws.
3. If the practice decides to provide nonurgent care to patients accompanied by someone other than their custodial parent or legal guardian, then it should establish a policy and procedural guide for the office as well as a patient information sheet explaining the policy. This statement may spell out the parent's responsibilities in providing and

PREAUTHORIZATION TO TREAT MINORS CONSENT FORM

For families who are ongoing patients of _____.
(pediatrician or health care facility)

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment for your minor child(ren) in advance. Be advised that protected patient health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making.

AUTHORIZATION

I (we) have the legal right to preauthorize this facility to deliver medical treatment to my (our) child(ren). I (we) request and authorize _____
(pediatrician or health care facility)

and its personnel to deliver medical care to my (our) child(ren) listed below:

Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

LIMITATIONS

Identify any limitations on the kinds of medical services for which this authorization is given. If none, state "none."
_____
_____
_____
Identify any limitations on the time frame for which this authorization is given. If none, state "none."
_____
_____
_____

CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) children at the following telephone number(s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

Parent's Name: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

Parent's Name: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

IN WITNESS WHEREOF, the undersigned have executed this instrument as of the ___ day of _____, 2___.

_____
Parent or Legal Guardian

_____
Parent or Legal Guardian

[If required by applicable law
NOTARIZATION

I, the undersigned, a Notary Public, do hereby certify that the persons whose names are subscribed to the foregoing instrument appeared before me this day in person and acknowledged that they signed and delivered the foregoing instrument as their free and voluntary act for the purposes set forth therein.

Given under my hand and seal this ___ day of _____, 2_____.]

This form, which should not be considered a legal document without advice from a lawyer, may be used as a template for documenting preauthorization or consent by proxy for nonurgent pediatric care.

Fig 1. Example consent form for preauthorization to treat minors.

CONSENT BY PROXY FOR NONURGENT PEDIATRIC CARE FORM

For families who are ongoing patients of _____.
(pediatrician or health care facility)

I (we) appoint _____, who is my (our)
(Name) (address)

child(ren)'s _____ as my (our) proxy decision maker for
(specify nature of proxy's relationship to children)

consenting to nonurgent medical care for my (our) children listed below. I (we) have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. Be advised that protected patient health information may be shared with the proxy to facilitate informed decision making.

Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

LIMITATIONS

Identify any limitations on the kinds of medical services for which this consent by proxy is given. If none, state "none."

_____
_____
_____

Identify any limitations on the time frame for which this consent by proxy is given. If none, state "none."

_____
_____
_____

CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) children at the following telephone number(s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

Parent's Name: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

Parent's Name: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

IN WITNESS WHEREOF, the undersigned have executed this instrument as of the ___day of _____, 2____.

_____
Parent or Legal Guardian

_____
Parent or Legal Guardian

_____
Proxy Decision Maker

_____
Driver's License Number of
Proxy Decision Maker

[If required by applicable law
NOTARIZATION

I, the undersigned, a Notary Public, do hereby certify that the persons whose names are subscribed to the foregoing instrument appeared before me this day in person and acknowledged that they signed and delivered the foregoing instrument as their free and voluntary act for the purposes set forth therein.

Given under my hand and seal this ____ day of _____, 2_____.]

This form, which should not be considered a legal document without advice from a lawyer, may be used as a template for documenting preauthorization or consent by proxy for nonurgent pediatric care.

Fig 2. Example consent by proxy for nonurgent pediatric care form.

documenting their consent by proxy arrangement. Make sure your office staff members understand the policy and their responsibilities in implementing the procedure, particularly those involved in telephone triage and scheduling appointments. Again, it is advisable to have legal counsel review these documents before implementing them.

4. It is advisable to create a template form to be used in cases in which individuals other than guardians or custodial parents may be expected to accompany a child to the office. Suggested items to address include:
   a. Who has legal right to delegate consent to health care decisions for the child?
   b. To whom can the power to consent to health care for a child be delegated?
   c. In what circumstances can the power to consent to health care for a child be delegated (eg, while child is vacationing out-of-state with grandparents or while parents are traveling overseas and child remains home with the nanny)?
   d. For which services (eg, preventive care, immunizations, laboratory tests) can the power to consent to health care for a child be delegated?
   e. With what limitations can the power to consent to health care for a child be delegated? (eg, limited to initial treatment for nonurgent acute care but not authorized to consent to follow-up care/referral to specialists. For example, the proxy may consent to treatment for a child's sprained ankle, but may not be authorized to take child to referred visit with the orthopedic surgeon).
   f. How is authorization of proxy consent verified and documented?
   g. When or how often should information on proxy consent be updated?

   It is advisable to have legal counsel review the template to ensure that it adequately covers all applicable laws.
5. Verify that the parent or surrogate accompanying the patient is the same person to whom proxy has been delegated on the aforementioned form. Requesting a dated signature and photograph identification from the surrogate is one way to document that verification. Dissimilar signatures may indicate a problem. Also, check to be sure that the person is authorized to consent to the specific care that will be provided. Legal counsel may offer additional suggestions for verifying the surrogate's ability to consent to the patient's care.
6. Establish an office procedure for providing and documenting informed consent for non–English-speaking patients or parents or proxies that conforms with federal and applicable state laws. If a translator is used, the practice may need to record and retain on file the name, address, and background of the translator. Translators need to be instructed that they are to communicate the caregiver's answer directly. The appropriate translated versions of VISs should be provided to parents with limited English proficiency.
7. In clinical situations with increased potential for problems related to consent, it may be prudent to contact the parent or legal guardian by telephone before rendering nonurgent care. If parental permission is secured via telephone, it should be documented and kept in the patient's chart. If the parent or guardian cannot be reached and the pediatrician decides to provide the care, then the efforts to contact the parent or legal guardian to obtain parental permission for care should be documented and kept in the patient's chart. A legal opinion could be sought on whether the use of witnesses is necessary when obtaining consent by telephone.

Sample template forms (Figs 1 and 2) for preauthorization of care for minors and consent by proxy are available at http://www.aap.org.

DISCLAIMER

The information contained in this report is provided for educational purposes only and should not be used as a substitute for licensed legal advice.

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