Dear Parent/Guardian:

We are glad you have chosen a Thompson Practice for your child's medical care and value the opportunity to see your child grow and develop.

We believe that communicating directly with you and your child is a central part of our relationship and to the maintenance of your child's health. We understand that periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. Being parents ourselves, we understand these circumstances. However, we must have a written authorization from you allowing the person accompanying your child to make medical decisions for him/her. This authorization gives the person permission to speak to the medical provider, give authorization for treatment, vaccinations, and medications and to make general health decisions.

Please note that without this paperwork, we may have to reschedule your child's appointment. To prevent this, we have included a copy of our form for your convenience. Please read it over carefully, noting the timeframes, and provide this form to us when circumstances arise. We are also able to accept a letter with the same information for the same timeframes.

We thank you in advance for your assistance with this process and look forward to being part of your child's care.

The Staff of the Thompson Medical Practices

part of F.F. Thompson Hospital

DESIGNATION OF PERSON IN PARENTAL RELATION CAREGIVER)

NOTE: A SEPARATE FORM IS NECESSARY FOR EACH CHILD

§ 5-1551.

Part A. (To be filled out by Parent(s))

We/I, _____, parent(s) of _____,
date of birth _____, designate _____ to be the

Education

Health

in accord with the laws of the State of New York, and to have full authority for one or both areas that are checked above

for a period of no more than _____ days/months (circle one) from my authorization.

(Note: The authority may be valid for up to twelve months).

ACKNOWLEDGEMENT IN NEW YORK STATE

(document must be notarized for designations of more than 30 days)

STATE OF NEW YORK,
COUNTY OF: _____

On _____ before me, the undersigned personally appeared, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____

PART B. (To be filled out by Caregiver)

(Note: The caregiver may sign this form at any time after the parent signs, it is not necessary for the form to be signed by both the parent and caregiver on the same day)

I, _____, the caregiver, hereby consent to assume the responsibilities and duties of a person in parental relation.

_____

ACKNOWLEDGEMENT IN NEWYORK STATE

STATE OF NEW YORK,
COUNTY OF: _____

On _____ before me, the undersigned personally appeared, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____