- ☐ Apple Hill Surgical Center
- ☐ Chambersburg Health Services
- ☐ Ephrata Community Hospital
- ☐ GSH Outpatient Surgery Center
- ☐ Philhaven
- ☐ The Chambersburg Hospital
- ☐ The Gettysburg Hospital
- ☐ The Good Samaritan Hospital of Lebanon
- ☐ Waynesboro Hospital
- ☐ WellSpan Dr. Roy A. Himelfarb Surgery Center
- ☐ WellSpan Medical Group
- ☐ WellSpan Surgery and Rehabilitation Hospital
- ☐ WellSpan Surgery Center - Hanover
- ☐ WellSpan Surgical Center
- ☐ York Hospital

If label not available, please fill in below.

NAME: ____________________

DOB: ____________________

MRN: ____________________

DELEGATED MEDICAL CONSENT FOR MINORS

I, ____, am the

☐ Parent of the child listed below and there are no court orders now in effect that would prohibit me from giving this consent.

☐ Legal guardian or legal custodian of the child by court order (copy attached, if available) and there are no other court orders in effect that would prohibit me from giving this consent.

I give the following person(s) the power to consent to necessary medical or mental health treatment of (name of child): ____________________________________.

☐ **I do not give any power to consent.**

#1	**#2**
Delegated Adult Printed Name: ____________________	Delegated Adult Printed Name: ____________________
Delegated Adult Signature: ____________________	Delegated Adult Signature: ____________________
Address: ____________________	Address: ____________________
The person(s)named above may consent to the child's examination and/or treatment, specified below:	The person(s)named above may consent to the child's examination and/or treatment, specified below:
☐ Medical ☐ Dental ☐ Surgical ☐ Immunizations ☐ Developmental and/or mental health	☐ Medical ☐ Dental ☐ Surgical ☐ Immunizations ☐ Developmental and/or mental health
I agree that the above-named adult(s): ☐ May go into the room with my child. ☐ May <u>Not</u> go into the room with my child.	I agree that the above-named adult(s): ☐ May go into the room with my child. ☐ May <u>Not</u> go into the room with my child.

This form is in effect until the minor reaches 18 years of age. I understand I have the right to revoke or make changes to this consent should I wish to do so.

Parent/Guardian Signature	Printed Name	Date	Time
Adult Witness #1 Signature	Printed Name	Date	Time
Adult Witness #2 Signature	Printed Name	Date	Time

Form #10384 Rev. (01/23)
Delegated Medical Consent for Minors