**North Office**
4811 Buckley Road
Liverpool, NY 13088
TEL (315) 457-9966
FAX (315) 457-9854

**Summerwood Pediatrics**

**West Office**
5700 W. Genesee St.
Camillus, NY 13031
TEL (315) 488-2868
FAX (315) 488-6759

# Parental Designation

1. I _____ am/are the parent(s) of

   Childs Name: _____ whose D.O.B is _____ and

   I/we have the power to make medical decisions for my/our child. There are no court orders that limit power

   or that prohibits me/us from making this designation.

2. By signing below, I/we designate _____ and

   _____, a person(s) over the age of eighteen,

   to have parental relation to my child named above.

3. This designation can be revoked by either parent at any time in writing.

4. **Contact Information of Parent(s) and Designee(Listed above only)-** During the period of this designation:

| | Name | Address | Phone |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Designee | | | |
| Designee | | | |

5. The person(s) I designate on this form shall have all the powers and duties permitted or imposed by NYS law of a person in a parental relation except:

   **List any exceptions:** _____

6. This authorization is good for ONE YEAR from the date of signature below unless revoked in writing.

**Mother's Signature:** _____ **Date:** _____

**Father's Signature:** _____ **Date:** _____