Medical Treatment Authorization and Consent

I/We, ____, being the (Check one) ☐ parent(s) ☐ legal guardian(s) of ________________________ [Child] authorize ________________________ [Caregiver] to seek, obtain and consent to: (Check all that apply)

- ☐ Routine medical care and treatment
- ☐ Emergency medical care and treatment
- ☐ Surgery
- ☐ Other: ____________________________
- ☐ Hospitalization
- ☐ Blood transfusions
- ☐ Dental care and treatment

for ________________________ [Child] as deemed necessary by a licensed medical or healthcare professional. This authorization is for the time period when my/our child is in the care of ________________________ [Caregiver], my/our child's: (Check one)

- ☐ Grandmother
- ☐ Grandfather
- ☐ Aunt
- ☐ Uncle
- ☐ Other: ________________
- ☐ Nanny
- ☐ Baby-sitter
- ☐ Family friend
- ☐ Teacher

and is effective _____ day of _______________, 20_____ until (Check one) ☐ _____ day of _______________, 20_____ ☐ revoked by me/us.

Child's Information

Child's Full Name: ________________________
Address: ___________________________________
Date of Birth: _______________________ **Age:** __________ **Sex:** ☐ Female ☐ Male

Parent/Guardian's Information

Parent's/Guardian's Name: ________________________
Address: ____
Phone Number (H): ______________________ **Phone Number (C):** ______________________
Phone Number (W): ______________________ **Email:** ___________________________

Parent/Guardian's Information

Parent's/Guardian's Name: ________________________
Address: ____
Phone Number (H): ______________________ **Phone Number (C):** ______________________
Phone Number (W): ______________________ **Email:** ___________________________

Emergency Contact Person's Information

Emergency Contact's Name: ______________________

Phone Number (H): ______________________ **Phone Number (C):** ______________________

Phone Number (W): ______________________ **Email:** ___________________________

Alternative Emergency Contact Person's Information

Alternative Emergency Contact's Name: ______________________

Phone Number (H): ______________________ **Phone Number (C):** ______________________

Phone Number (W): ______________________ **Email:** ___________________________

Child's Health Information

Health Conditions (e.g. Asthma, Diabetes)**:** ____

Allergies (e.g. to Medications, Food)**:** ____

Prescription Medications: ____

Date of Last Tetanus Injection/Booster: ______________________

Child's Medical Care Information

Physician/Pediatrician: ______________________ **Phone Number:** ______________________

Dentist/Orthodontist: ______________________ **Phone Number:** ______________________

Preferred Medical Facility: __________________________________

Insurance Company: _____________________________________

Policy/Group Number: ______________________ **Policy Holder:** ______________________

Signature of Parent/Guardian

Signature

____

Print Name **Date**

______________________________________ ____

Signature

____

Print Name **Date**

______________________________________ ____

Witness

Witness 1 Signature

Print Name ______________________ **Date** ______________________

Address ______________________

Witness 2 Signature

Print Name ______________________ **Date** ______________________

Address ______________________

Notary Acknowledgment

State of ___________________
County of ___________________

On this _____ day of ________________, 20_____ in the year 20_____ before me, _________________________, appeared _________________________, who is personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

Notary Seal

____
(**Signature** of Notary Public)

My Commission Expires: ___________________(**Date**)