APPOINTMENT OF AGENT FOR MINOR CHILD(REN)

____, the undersigned parent, hereby grant:

Name: ______________________________ Street Address: __________________________________

City/ State: ____________________________ Zip Code: _________________________

Home Telephone Number: _____________________ Work Telephone Number**:** _________________

Cellular Telephone Number: ____________________ E-Mail Address: __________________________

Relationship to Minor(s): ________________________ Date of Birth:____________________________

the authority to obtain medical treatment for the following child(ren):

Name of Minor: _____________________________ Name of Minor: _____________________________
Date of Birth: ________-________-________ Date of Birth: ________-________-________

Name of Minor: _____________________________ Name of Minor: _____________________________
Date of Birth: ________-________-________ Date of Birth: ________-________-________

The above named care provider(s) shall have the authorization to obtain medical treatment and procedures for the children as may be appropriate in emergency circumstances and routine medical treatment, including treatment by physicians, hospital, clinic personnel, and other appropriate health care providers.

This grant of temporary authority shall begin on ________-________-________ and shall remain effective until ________-________-________.

I, _____________________________of____,

(Parent Name) (Street Address)

___________________, __________, _____________ make oath and say that I am lawful guardian

(City) (State) (Zip Code)

of the child(ren) listed above and there are no court orders now in effect that would prohibit me from conferring the power to consent upon another person.

-I authorize my temporary care provider to consent to any and all health care examinations or treatments for my child(ren), including mental health, medical, surgical, dental, developmental, or psychological.
-I authorize my temporary care provider access to any medical records or insurance records related to the health care treatment of my child(ren).

I hereby authorize and appoint ____as my agent.

SIGNATURE

Signature: ____ Date: ____________

(Parent or Legal Representative)

Relationship ________________________ Witness ___________________________________ Date ________________

Relationship ________________________ Witness ___________________________________ Date ________________