MEDICAL TREATMENT AUTHORIZATION FOR A MINOR CHILD

Appointment of Agent For Minor Child

_____, 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:

Name of Minor: _____

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 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.

I hereby authorize and appoint _____as my agent

Signature:_____ Date: _____

(Parent or Legal Representative)

Relationship _____ Witness _____ Date _____