Authorization to Consent to
Medical Care for a Minor Child

Date: _____

(Valid for one year from provided date, unless otherwise specified)

I/We _____

(Name(s) of Parent(s)/Guardian(s)

_____

(Address & Phone Number)

do hereby state that I/We are the parent(s) /guardian(s) have legal custody of

_____ **_____**

(Child's Name & Birthdate) (Child's Name & Birthdate)

_____ _____

(Medical History, Allergies, Medications) (Medical History, Allergies, Medications)

and authorize

_____

(Adult into whose care minor(s) is entrusted & their relationship to child)

_____

(Entrusted Adult's Address, Home, & Relationship to Child)

To consent to all necessary & appropriate medical care, including but not limited to diagnostic examination, immunizations, anesthetic & hospital care to be rendered to the minor at a recognized medical facility under the general or special supervision of a licensed physician.

I understand that if an injury/illness is determined to be life threatening, my provider will make every effort to contact me. If I am unreachable, the above entrusted adult my consent to emergency care for my child.

By my signature, I acknowledge that I have read & understand this consent to authorize medical care to my minor child.

_____

(Signature of Parent/Guardian)