AUTHORIZATION TO CARE AGENT FOR MEDICAL TREATMENT OF CHILD

Parent Information

- Parent Name_____
- Parent DOB_____
- Parent Address_____
- Parent Phone Number_____

I am the lawful guardian of the child listed below and there are no court orders now in effect that would prohibit me from conferring the power to consent upon another person.

Child Information

- Child Name_____
- Child DOB_____ Child Sex_____
- Child Address_____

Authorized Care Agent

I, hereby give my consent to allow the following authorized person/s:

- Name(s) _____
- Relationship to Child _____
- Address_____
- Phone_____

My agent/s may consent to my child's medical examination or treatment. Such treatment may include but is not limited to the following:

- Examination
- X-rays
- Medication
- Treatment

This authorization shall remain valid until, Date:_____ or; until the consent is withdrawn or; until the minor reaches the age of majority.

Signature:_____ Date: _____

Printed Name:_____