Authorization For Another To Consent To Treatment Of Children

As a parent/legal guardian of the following children:

Name_____ Birth Date_____

Name_____ Birth Date_____

Name_____ Birth Date_____

I hereby authorize:

Name _____

Address _____

Phone # _____

who is 18 years of age or older to consent to any medical or surgical treatment of the above child/ren as determined necessary by a medical provider for the welfare of my child/ren when a parent/legal guardian cannot be reached. **The above authorization will be effective from _____ to _____ but will last no longer than 6 MONTHS**.

Signature _____
Parent/Guardian

Parent/Guardian Phone # _____

Employer's Phone # _____

Is it okay for the authorized person to sign for immunizations?

□ YES □ NO

Name of child _____

Chronic Illness or Allergies _____

Current Medications _____

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Chronic Illness or Allergies_____

Current Medications _____