Medical Treatment Authorization and Consent

I, _____, being the

(**Check one**) ☐ parent ☐ legal guardian of _____ [Child]

authorize_____[Caregiver] to seek, obtain and consent to:

(**Check all that apply**)

☐ Routine medical care and treatment ☐ Appointment scheduling
☐ Vaccinations/Immunizations ☐ Emergency medical care and treatment
☐ Other: _____

for _____ [Child] as deemed necessary by a licensed medical or healthcare professional. This authorization is for the time period when my child is in the care of

_____ [Caregiver], my child's:

(**Check one**)

☐ Grandmother ☐ Aunt
☐ Grandfather ☐ Uncle
☐ Step-parent ☐ Family friend
☐ Adult sibling ☐ Nanny / Babysitter
☐ Other: _____

and is effective _____ day of _____, 20_____ until

(**Check one**) ☐ _____ day of _____, 20_____ ☐ revoked by me.

Child's Information

Child's Full Name: _____

Address: _____

Date of Birth: _____

Caregiver's Information

Caregiver's Name: _____

Address: _____

Phone Number (H): _____ Phone Number (C): _____

Parent's/Guardian's Information

Parent's/Guardian's Name: _____

Address: _____

Phone Number (H): _____ Phone Number (C): _____

Phone Number (W): _____ Email: _____

Notary Acknowledgment

Signature: _____

Print Name: _____ Date: _____

State of _____

County of _____

On this _____ day of _____, 20_____ in the year 20_____ before me,

_____, appeared _____, who is personally known
(Notary) (Name of party/individual)

to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

Notary Seal:

Signature of Notary Public: _____

My Commission Expires: _____