AUTHORIZATION AND CONSENT
FOR MEDICAL TREATMENT

I, ______________________ (Full Legal Name of Parent/Guardian), being the parent/legal guardian of:

1. ____________________ ____________
   Child's Full Name DOB
2. ____________________ ____________
   Child's Full Name DOB
3. ____________________ ____________
   Child's Full Name DOB
4. ____________________ ____________
   Child's Full Name DOB
5. ____________________ ____________
   Child's Full Name DOB

authorize, *other than parent(s)/guardian(s)* the following named individual(s) to care for my child(ren) in my absence:

1. ____________________ ________________
   Full Name of Caregiver Relationship to Patient
2. ____________________ ________________
   Full Name of Caregiver Relationship to Patient
3. ____________________ ________________
   Full Name of Caregiver Relationship to Patient

To seek, obtain and consent to routine medical care and treatment/emergency medical care and treatment, procedures and vaccinations for my child/children listed above as deemed necessary by a licensed medical or healthcare professional. ***This authorization is in effect during the time my child is in the care of the person/people listed above and is effective for a period of 12 months from the date signed below***. I understand that I may revoke/edit this consent at any time.

☐ **At this time *I DO NOT* wish to give consent to anyone except parent(s)/guardian(s)**

____
Name of Legal Guardian (Print)

____
Signature of Legal Guardian

____
DATE

REVISED 01/04/2021