AUTHORIZATION FOR NON-PARENT TO CONSENT FOR CARE

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

I have legal custody of the minor child(ren) named above. I grant my authorization and consent for the Supervising Adults named below to seek medical treatment for the child(ren).

The Supervising Adult(s) are listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorizes the above-named person(s) to consent for:

- ☐ Medical Care
- ☐ Immunization
- ☐ Medication Injection
- ☐ Prescriptions
- ☐ Labs

This will remain in effect until revoked in writing by me. I hereby attest that I have legal authority to delegate my authority to consent for care, and that no legal agreement prevents me from delegating authority

_____

Printed Name of Parent/Legal Custodian

_____ _____

Signature Date