AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

I ____ (Name of Parent/Legal Guardian) residing

at ____ (Guardian's address) acknowledge that I

am the lawful parent/guardian of ______________________ (Name of child) ___________ (DOB of child) and that there are no court orders or other documents in effect that would prevent me from conferring the power of consent to another person.

I hereby authorize and appoint the following adults to consent to my child's medical examination and treatment. I give this consent voluntarily in order to make sure that my child receives adequate healthcare. The following adults include:

Name	Relationship	Address	Phone Number

Limitations: Identify any limitations on the kinds of medical services for which authorization is given. If non, state "none." ____

Contact: If the nature of the medical care is not routine, please try to contact me. If you are unable to contact me for any reason, you may rely on the proxy decision-maker for consent. My contact information is: ____.

Signed and dated on: ________________

Parent/Legal Guardian: ____________________ ____________________
Signature Printed Name

Witness ____________________ ____________________
Signature Printed Name

Witness: ____________________ ____________________
Signature Printed Name