**Non-Parent Guardian Authorization for Consent to Medical Care and Treatment**

I, ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent/legal guardian of the child(ren) listed below do hereby give my authorization and consent for the below named person(s) to consent to the medical care and treatment of my child(ren). I hereby authorize and grant that the below named person(s) has/have permission from the natural parent or legal guardian to sign for any and all medical procedures or treatments deemed necessary for the well-being of my child(ren).

I am, by this document, representing that I have the authority to consent for all medical care and treatment of said child(ren).

This authorization is for:

\_\_\_\_Today’s date only.

­­\_\_\_\_A specific date of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_All future visits effective for one year from today’s date.

I realize that it is my duty to update and notify my physician’s office of any necessary changes that must be made to this document within a timely manner. I also understand that to ensure this document is accurate. I will be required to complete it annually.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Relationship to child(ren) Date

Child(ren):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Name Name