

Child Medical Consent

I/We, _____, being the (Check one) parent(s)

legal guardian(s) of _____ [Child] authorize _____
[Caregiver] to seek, obtain and consent to: (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Routine medical care and treatment | <input type="checkbox"/> Hospitalization |
| <input type="checkbox"/> Emergency medical care and treatment | <input type="checkbox"/> Blood transfusions |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Dental care and treatment |
| <input type="checkbox"/> Other: _____ | |

for _____ [Child] as deemed necessary by a licensed medical or healthcare professional. This authorization is for the time period when my/our child is in the care of _____ [Caregiver], my/our child's: (Check one)

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Grandmother | <input type="checkbox"/> Nanny |
| <input type="checkbox"/> Grandfather | <input type="checkbox"/> Baby-sitter |
| <input type="checkbox"/> Aunt | <input type="checkbox"/> Family friend |
| <input type="checkbox"/> Uncle | <input type="checkbox"/> Teacher |
| <input type="checkbox"/> Other: _____ | |

and is effective _____ day of _____, 20____
until (Check one) _____ day of _____,
20____ revoked by me/us.

Parent's Information

Parent's Full Name: _____

Address: _____

Date of Birth: _____ Age: _____ Sex: Female Male

Parent/Guardian's Information

Parent's/Guardian's Name: _____

Address: _____

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

Work Number (W): _____ Email: _____

Parent/Guardian's Information

Parent's/Guardian's Name: _____

Address: _____

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

Work Number (W): _____ Email: _____

Emergency Contact Person's Information

Emergency Contact's Name: _____

Phone Number (H): _____

Phone Number (C): _____

Phone Number (W): _____

Email: _____

Alternative Emergency Contact Person's Information

Alternative Emergency Contact's Name: _____

Phone Number (H): _____

Phone Number (C): _____

Phone Number (W): _____

Email: _____

Child's Health Information

Health Conditions (e.g. Asthma, Diabetes): _____

Allergies (e.g. to Medications, Food): _____

Prescription Medications: _____

Date of Last Tetanus Injection/Booster: _____

Child's Medical Care Information

Physician/Pediatrician: _____ **Phone Number:** _____

Dentist/Orthodontist: _____ **Phone Number:** _____

Preferred Medical Facility: _____

Insurance Company: _____

Policy/Group Number: _____ **Policy Holder:** _____

Signature of Parent/Guardian

Signature

Print Name

Date

Signature

Print Name

Date

Witness

Witness 1 Signature

Print Name

Date

Address

Witness 2 Signature

Print Name

Date

Address

Notary Acknowledgment

State of _____

County of _____

On this ____ day of _____, 20____ in the year 20____ before me,
_____, appeared _____, who is personally known 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: _____(Date)