MEDICAL CONSENT AUTHORIZATION

I, _____, am the parent or guardian of the child/children
(Parent or Guardian's Name)
listed below. There are no court orders that would prohibit me from giving the power of consent to another person, and hereby give _____, _____,
(Name of Person/Persons Given Power)
_____,
(Name of Person/Persons Given Power)
the power to consent to any necessary medical/surgical, emergency or mental/developmental health care in my absence as indicated below.

1. _____ Birthdate: ____/____/____
Last First Middle Initial

2. _____ Birthdate: ____/____/____
Last First Middle Initial

3. _____ Birthdate: ____/____/____
Last First Middle Initial

4. _____ Birthdate: ____/____/____
Last First Middle Initial

5. _____ Birthdate: ____/____/____
Last First Middle Initial

I, _____. am the parent or guardian of the child/children listed
(Parent or Guardian's Name)
above and hereby give consent for my child/children, 16 or 17 years of age (minors), to receive any necessary medical/surgical, emergency or mental/developmental health care as indicated above in my absence.
This document shall remain in effect until it is revoked by my written notification to my child's/children's medical provider and the person named above. Therefore, I hereby sign my name to this *Medical Consent Authorization* in the presence of my witness on ____/____/____.

_____ _____
(Print Name of Parent or Guardian) (Signature of Parent or Guardian)

_____ _____
(Print Name of Witness) (Signature of Witness)