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# Authorization for Non-Parent to Consent to Care

I am the parent/legal guardian of:

Patient's Name: ________________________________________________ DOB: ____________

Patient's Name: ________________________________________________ DOB: ____________

Patient's Name: ________________________________________________ DOB: ____________

Patient's Name: ________________________________________________ DOB: ____________

☐ **I do not authorize any other person to consent to care for my child(ren):**

☐ **I authorize the following persons to seek medical care for the above listed child(ren):**

Name: ____________________________________ Relationship to Patient: __________________

Name: ____________________________________ Relationship to Patient: __________________

Name: ____________________________________ Relationship to Patient: __________________

Name: ____________________________________ Relationship to Patient: __________________

This authorization permits the above-named persons to consent for:

☐ Medical Care ☐ Labs ☐ Vaccinations ☐ Antibiotic Injections ☐ Prescriptions

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

Signature: _____________________________________ Date: __________________________

Relationship to patient(s): ☐ Mother ☐ Father ☐ Legal Guardian