AUTHORIZATION TO CONSENT TO MEDICAL AND DENTAL TREATMENT FOR MINOR CHILD TO ADULT NONPARENT

We, _____,

Of _____, City of _____,
(address)
County of _____, State of _____, the parents

Having legal custody of _____,
(name and age of minor child)

who reside(s) with us at the address set forth above, do hereby authorize

_____,

an adult in whose care the minor(s) has/have been entrusted, and who reside at

_____, City of _____,

County of _____, State of _____, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care, to be rendered to the minor(s) under the general or special supervision and on the advice of any physician or surgeon, and to consent to any X-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care, to be rendered to the minor by any dentist.

This authorization covers the following time period: _____ through

_____.

Minor Child's Social Security Number _____

_____ _____
(Parent Signature) (Parent Signature)

Date _____ 20_____.

State Of _____ County of _____

Before me, the undersigned, a Notary Public in and for said County and State on this _____ day of _____, 20_____, personally appeared _____ to me known to be the identical person(s) who executed the foregoing instrument and acknowledged to me that _____ executed the same as _____ free and voluntary act and deed for the uses and purposes therein set forth.

My commission expires: _____ _____
(Notary Public)

Copyright © 2009, AgEdToolbox, LLC – Educational Resource Materials