PARENT/GUARDIAN AUTHORIZATION TO TREAT DEPENDENT/MINOR CHILD(REN)

I delegate my authority to consent for the health care of my dependent/minor child(ren) named:

_____

for a period of time when I will not be reasonably available to exercise my authority.

I delegate my authority to the following person: (please print)_____,

[Address _____ Phone: _____] **except as specified below.**

This authorization of consent is to be exercised in good faith and in the best interest of my dependent/minor child, subject to the following limitations (or if none, write "none"):

_____

_____

This authorization of consent is effective on the _____ day of _____, 20___ and will continue until the _____ day of _____, 20____.

Please check one:

- ☐ I authorize the individual which I have delegated authority to, to delegate the authority to another.
- ☐ I do not authorize the individual which I have delegated authority to, to delegate the authority to another.

Dated this _____ day of _____, 20_____.

_____
(Printed Name)

_____, Appointer
(Parent/Guardian signature)

Address_____Phone_____

Witness:
I declare that I am an adult at least eighteen (18) years of age and that at the request of the above-named individual making the appointment (Appointer), I witness the signing of this document by that Appointer on the date noted above.

_____
(Printed Name)

_____
(Signature of person accepting authority of consent)

Address_____Phone _____