

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OF CHILD

1. I, _____ of _____, _____, California, _____, _____ make oath and say that I am the lawful guardian of the child listed below and there are no court orders now in effect that would prohibit me from conferring the power to consent upon another person.

First Child

_____, male, born **(Month/Day/Year)** at _____ and residing at _____, _____, California, _____, _____.

2. I hereby authorize and appoint _____ of _____, _____, California as my agent. My agent may consent to my child's medical examination or treatment. Such treatment may include but is not limited to the following:

- | | |
|--------------------------------|--------------------|
| a. transportation by ambulance | e. hospitalization |
| b. examination | f. anesthesia |
| c. x-rays | g. medication |
| d. diagnoses | |

I do not authorize _____ to consent to the transfusion of blood.

3. I give this consent freely and knowingly in order to provide for the child and not as a result of pressure, threats or payments by any person or agency.
4. This consent will remain in effect until it is revoked by notifying my child's medical, mental health care and insurance providers, in writing, and the agent named above that I wish to revoke it.
5. Any questions or concerns regarding this authorization may be directed to me at:

Name: _____
Street Address: _____
City: _____, California
Zipcode: _____
Country: _____

Name: _____
Street Address: _____
City: _____, California
Zipcode: _____
Country: _____

Home Phone: (_____) _____ - _____
Work Phone: (_____) _____ - _____
Cell Phone: (_____) _____ - _____
Email: _____

Home Phone: (_____) _____ - _____
Work Phone: (_____) _____ - _____
Cell Phone: (_____) _____ - _____
Email: _____

IN WITNESS WHEREOF, I hereunto sign my name at _____, California this
_____.

Witness

Witness

Print Name

Print Name