MEDICAL CONSENT AUTHORIZATION FOR MINOR CHILDREN

**Please Print All Information Below**

[ ] I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am the parent of the child(ren) listed below, and there are no court orders now in effect that would prohibit me from conferring the power to consent upon another person.

Name of Parent

[ ] I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am the legal guardian or legal custodian of the child(ren) by court order (copy attached, if available), and there are no other court orders in effect that would prohibit me from conferring the power to consent upon another person.

Name of Legal Guardian/Custodian

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby confer upon ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, residing at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the power to consent to necessary medical or mental health treatment for the following child(ren):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, residing at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, born on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and on the child(ren)’s behalf do hereby state that the power to consent which I confer shall not be affected by my subsequent disability or incapacity.

Birthdate of Child(ren)

Name of Child(ren)

Address of Child(ren)

Name of Medical Consent Designee

Address of Medical Consent Designee

Name of Parent/Legal Guardian/Custodian

The power which I confer is specifically limited to health care and mental health care decision making, and it may be exercised only by the person named above.

The person named above may consent to the child(ren)’s (cross out all that do not apply): medical, dental, surgical, developmental, and/or mental health examination or treatment and may have access to any and all records, including, but not limited to, insurance records regarding any such services.

I confer the power to consent freely and knowingly in order to provide for the child(ren) and not as a result of pressure, threats, or payments by any person or agency. This document shall remain in effect until it is revoked by notifying my child(ren)’s medical, mental health care, and insurance providers, in writing, and the person named above that I wish to revoke it.

In witness whereof, I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have signed my name to this medical consent authorization, consisting of 2 pages on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County, Pennsylvania.

Date of Signing

Name of County

Name of Parent/Legal Guardian/Custodian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Legal Guardian/Custodian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent/Legal Guardian/Custodian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of First Witness

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of First Witness

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of First Witness

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Second Witness

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Second Witness

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Second Witness

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Medical Consent Designee

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medical Consent Designee