THIRD PARTY CONSENT
AUTHORIZATION FOR MEDICAL TREATMENT

Please complete this form if you give anyone other than the legal parent/guardian authorization to accompany patient at appointments. (Example: Grandparent)

I, ____, being the parent/legal guardian of:
(Full Legal Name of Parent/Guardian)

1. ____ ______________________
   Child's Full Name DOB

2. ____ ______________________
   Child's Full Name DOB

3. ____ ______________________
   Child's Full Name DOB

4. ____ ______________________
   Child's Full Name DOB

Authorize,

1. ____ ______________________
   Full Name of Caregiver Relationship to Patient

2. ____ ______________________
   Full Name of Caregiver Relationship to Patient

3. ____ ______________________
   Full Name of Caregiver Relationship to Patient

to seek, obtain and consent to routine medical care and treatment, emergency medical care and treatment, procedures and vaccinations for my child/children listed above as deemed necessary by a licensed medical or healthcare professional. This authorization is for the time period when my child is in the care of the person/people listed above and is effective ______________________________ (Date). This authorization will remain in effect until revoked. I may revoke or edit this consent at any time.

____/____/____________________
Print Name of Parent/Guardian **Signature of Parent/Guardian** **Date**

__________________________________ ___ ________________________
Signature of Office Staff **Date**

____/____/____________________
Print Name of Parent/Guardian **Signature of Parent/Guardian** **Date**
*****(Only sign and date if no change from previous year)***

____/____/____________________
Print Name of Parent/Guardian **Signature of Parent/Guardian** **Date**
*****(Only sign and date if no change from previous year)***

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