



**AUTHORIZATION FOR AGENT TO  
CONSENT TO MEDICAL TREATMENT OF A  
MINOR**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize the following adults:

\_\_\_\_\_ (Relationship to minor)

\_\_\_\_\_ (Relationship to minor)

\_\_\_\_\_ (Relationship to minor)

into whose care the minor has been entrusted, to consent to any physical exam, medical procedures including immunizations and treatments deemed advisable by a licensed physician and provided by that physician or under that physician's supervision, regardless of where treatment is provided.

This authorization is made under California Family Code 6910.

Signed \_\_\_\_\_ Dated \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship to Minor: \_\_\_\_\_

( ) This authorization is to be in effect from \_\_\_\_\_ to \_\_\_\_\_.

( ) This authorization is to remain in effect until revoked by the above signed.