THIRD PARTY CONSENT
AUTHORIZATION FOR MEDICAL TREATMENT

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

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). I may revoke/edit this consent at any time.

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

___________________________________ ___ ________________
Signature of Office Staff **Date**