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Authorization for third party to Consent to Medical Treatment of a Minor Lacking Capacity to Consent

I am the: (Circle)

Parent
Guardian
Other person having legal custody:_____
(describe legal relationship)

of *(name of minor)* _____, a minor.

I hereby authorize (name of agent) _____, to act as my agent to consent to any x-ray examination, immunizations (based on the AAP guidelines), anesthetic, medical or surgical diagnosis or treatment and hospital care which is recommended by, and to be rendered under general or special supervision of, any licensed doctor, weather such diagnosis or treatment is rendered at the doctor's office or at a hospital.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority to the above-named agent to give consent to any and all such diagnosis, treatment, or hospital care which a licensed doctor recommends.

This authorization is under Family Code Section 6910.

This authorization shall remain effective until (*month and day*) _____, 20_____, unless sooner revoked in writing.

Mother's telephone number: _____

Father's telephone number: _____

Signed: _____ Dated: _____

Print Name: _____

Please specify relationship to minor (circle):

Parent with legal custody

Guardian with legal custody