MEDICAL CONSENT AUTHORIZATION FOR MINORS

___ I, _____, am the parent of the child listed below and there
(Parent's Name)
are no court orders now in effect that would prohibit me from conferring the power to consent upon another person.

___ I, _____, am the legal guardian or legal custodian of the
(Name of Legal Guardian or Legal Custodian)
child 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.

I, _____, do hereby confer upon _____
(Name of Parent/Legal Guardian/Custodian) **(Name of Person Bringing Child(ren for Care)**
residing at _____the power to consent to necessary medical treatments for the following child: _____,residing at: _____ born on:_____ and on the child's behalf do hereby state that the power to consent that I confer shall not be affected by my subsequent disability or incapacity.

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

The person named above may consent to the following examinations and treatment for my child. (check all that apply) ____medical, ____surgical, _____
(Other Treatment Child May Receive)
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 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 my written notification to my child's medical and insurance providers, and the person named above.

In witness whereof, I have signed my name to this medical consent authorization, on _____ in _____, Pennsylvania.

_____

(Parent or Legal Guardian/Custodian) **(Signature)**
(Printed Name)

_____

(Witness - Signature) **(Witness Printed Name and Address)**

_____

(Signature of Adult Person who is Being Given Power to Consent)