Medical Consent Form for Grandparents

I/We, _____, being the parent/s or legal guardian/s of _____, born on _____, do hereby authorize _____, of _____ to act in my/our absence to consent to necessary and appropriate medical or dental treatment and procedures, including but not limited to examination, anesthetics, medical, surgical or dental diagnosis and treatment for my/our child.

This authorization is effective from _____ to _____.

Child's medical information
Physician's name:
Physician's phone number:
Health Insurance company:
Known allergies:
Chronic conditions or other pertinent medical information:

Parent's/guardian's contact information
Address:
Phone number:
Email:

I/We can be reached at the above number at any time. In the event I/we cannot be reached, I/we have provided the contact information of an alternate contact below:

Alternate emergency contact
Name:
Relationship to child:
Phone number:
Email:

I/We understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power to our designee in the exercise of their best judgment upon the advice of any physician, dentist, or other health care provider. This authorization is given under the laws of the state of _____.

Signature of parent/guardian: _____

Printed name of parent/guardian: _____

Date: _____

Note: This form should be notarized if required by state law.