Permission to Treat Form

NOTE: This form is NOT valid for Preventative/Well Child exams/vaccines. Only Acute care.

Date:________________

To Whom It May Concern:

I,_________________________guardian of__________________________give my
(Biological Parent/Guardian’s Name) (Child’s Name)

Permission for: ________________________________________________
(Caretaker’s Name) (Relationship to Child)

________________________________________
(Caretaker’s Name) (Relationship to Child)

________________________________________
(Caretaker’s Name) (Relationship to Child)

...to seek medical treatment & make decisions for my child as necessary on my
behalf. The duration of this authorization is indefinite and continues until
revoked in writing.

Parents Signature___________________________________ Date_____________

Witness Signature___________________________________ Date______________