

Date \_\_\_\_\_

I (We) \_\_\_\_\_  
(Print Mother's Name) (Print Father's Name)

\_\_\_\_\_  
(Address)

Designate To \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Address)

THE POWER TO CONSENT IN MY (OUR) ABSENCE TO MEDICAL/DENTAL CARE FOR OUR CHILD(REN):

\_\_\_\_\_  
\_\_\_\_\_

I HEREBY DECLARE (i) that any medical or dental care rendered pursuant to this Consent is ratified and approved, (ii) that this Consent shall remain in full force and effect and, (iii) that the health care provider may rely on this Consent until written notice of its revocation shall have been delivered to and received by the health care provider.

Parents phone numbers: \_\_\_\_\_

Child(ren)'s Physician & Phone number: \_\_\_\_\_

Child(ren)'s Medical History \_\_\_\_\_

Chronic Conditions: \_\_\_\_\_

Medications needed on a regular basis: \_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

Dietary or other restrictions: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Mother)

\_\_\_\_\_ Date: \_\_\_\_\_  
(Father)

Signed and acknowledged in the presence of \_\_\_\_\_  
Notary Public

My commission expires: \_\_\_\_\_

