Delegation of Parental Authority

to Consent for Medical Care of a Minor

Instructions: Please print or type all information.

Name of Child: _____

Name(s) of Parent (s) or guardian: _____

Address and telephone: _____

_____

Consent authority delegated to: Victory Child Care, Inc. - Staff

The undersigned parent(s)/guardian(s) hereby authorize the above named person(s) to act as my/our agent and attorney-in-fact for the purpose of consenting to medical, dental, or hospital care and treatment of the named child. Such care and treatment is to be rendered by or under the supervision of a licensed practitioner, hospital or other health care facility. The agent is also authorized to have access to the health care history and records of the minor to the extent reasonably necessary to enable the agent to give informed consent for the minor's care and treatment.

Any health care practitioner or facility given an original or a photocopy of this document is authorized to honor the consent of the agent for care and treatment of the minor to the same extent as if consent were given by the parent(s)/guardian(s) personally.

OPTIONAL: This delegation of authority terminates on _____/_____/_____.

_____ Parent/Guardian Signature

_____ Parent/Guardian Signature

Sworn to before me this _____ day of _____, _____

_____

Witness