GRANDPARENTS MEDICAL CONSENT *FORM*

Name:		
The parent or legal guardian of		
Residing at *(Address)*		
Born on the	**day of**	**,20**
Do hereby consent and allow *(Grandparent)*		

to handle any type of medical care for my child including but not limited to the administration of anesthesia determined by a physician, surgery, and any other care recommended or deemed as necessary for the welfare of my child.

This authorization is effective from on this	**day of**	**,20**
And expires on the	**day of**	**,20**

Signature of Parent or Legal Guardian	**Signature of Witness**
Date:	**Date:**
Print Name:	**Print Name:**

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Father's Telephone::	**Mother's Telephone:**
Allergies to drugs or foods:	
Special Medications, Blood Type or Pertinent Information:	

Child's Physician:	**Phone:**
Insurance:	**:Policy #**