Authorization to Make Medical Decisions for Minor

Information & Instructions

What is the purpose of the Authorization to Make Medical Decisions for Minor?
This form allows you, as the parent or legal guardian, to temporarily appoint another individual as your Agent, to make health care decisions for the child. The appointment lasts only up to 60 days, and is intended for situations such as when a parent is temporarily out of state and the minor child is remaining with a family member or family friend.

What will the appointed agent be able to do?
Once this form is completed, the Agent will be able to make health care decisions for the minor child, on the parent or legal guardian’s behalf. The Agent can consent to medical treatment. This form does not authorize the Agent broad rights to access the minor child’s medical record. You do have the opportunity to limit the Agent’s authority, by setting forth any specific acts you do not want the Agent to perform in the appropriate section of the form.

What steps must I take to complete the form?
Section 1
Provide the information requested, including setting forth the limit on the Agent’s authority, if any. Your signature at the end of this section certifies that you have the legal right to make this appointment (in other words, that there is no court order prohibiting you from doing so).

Section 2
Section 2: You must have two witnesses sign and date the form, and print their name, address and telephone number. The witnesses must be over age 18, and neither witness can be the individual identified as the Agent.
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1. AUTHORIZING PARTY (Parent/Guardian)

I, ___________________________________, residing at ______________________________________________ am: □ the parent / □ legal guardian / □ legal custodian of the minor child(ren) listed below.

I do hereby authorize ___________________________________, residing at ______________________________________________, Phone #: ________________________ to exercise concurrently the rights to agent and make healthcare decisions for the minor children whose names and dates of birth are:

_____________________________________________________________________________________________

_____________________________________________________________________________________________

The caregiver may NOT do the following: (If there are any specific acts you do not want the caregiver to perform, please state those acts here.)

_____________________________________________________________________________________________

_____________________________________________________________________________________________

There are no court orders in effect that would prohibit me from exercising or conferring the rights and responsibilities that I wish to confer upon this individual. I understand that, if the affidavit is amended or revoked, I must provide the amended affidavit or revocation to all parties to whom I have provided this affidavit.

This document shall remain in effect until ____________ (not more than 60 days from today) or until I notify the individual in writing that I have amended or revoked it.

I hereby affirm that the above statements are true, under pains and penalties of perjury.

Signature: ___________________________________________ Date: ___________________

Printed name: ___________________________________________

Telephone number: ________________________________________

2. WITNESSES TO AUTHORIZING PARTY SIGNATURE

(To be signed by persons over the age of 18 who are not the designated caregiver.)

_____________________________________________ ____________________________________________

Witness #1 Signature                                                           Witness #2 Signature

Printed Name, Address and Telephone

_____________________________________________ ____________________________________________

_____________________________________________ ____________________________________________

_____________________________________________ ____________________________________________