FERNVALLEY
NATURAL HEALTH

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 last 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 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. You 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

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 custodian of the minor child(ren) list below.

I do herby authorize _____, residing at _____, Phone number _____

to exercise concurrently the rights to agent and make healthcare decisions for the minor child(ren) whose names and dates of birth are:

_____ _____

name and date of birth *name and date of birth*

_____ _____

name and date of birth *name and date of birth*

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 herby 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 person over age of 18 who are not the designated caregiver/agent)

_____ _____

Witness #1 Signature *Witness #2 Signature*

Printed Name, Address and Telephone **Printed Name, Address and Telephone**

_____ _____

_____ _____

_____ _____

_____ _____