Authorization to Consent to Medical Treatment of a Minor Child

I ____(Name of Parent/Legal Guardian)) residing at ____(Parent's Address) , New Hampshire, acknowledge that I am the lawful parent/guardian of _______________________(Name of Child) ________ (DOB of Child) and that there are no court orders or other documents in effect that would prevent me from conferring the power of consent to another person.

I hereby authorize and appoint ____(Name of Agent) residing at ____(Agent's Address), New Hampshire, to consent to my child's medical examination and treatment. I give this consent voluntarily in order to make sure that my child receives adequate healthcare. This authorization will remain in effect for a period not exceeding one year.

Limitations: Identify any limitations on the kinds of medical services for which authorization is given. If none, state "none." ____

Contact: If the nature of the medical care is not routine, please try to contact me. If you are unable to contact me for any reason, you may rely on the proxy decision-maker for consent.
Contact Information:____

Signed and dated this _____ day of _____________, 2014.

Parent/Legal Guardian ______________________________ ________________________
Signature Print Name

Witness_________________________________ _______________________________
Signature Print Name

Witness_________________________________ _______________________________
Signature Print Name

Notary _________________________________