Medical Authorisation for a Minor

The parent authorises the caregiver named below to act for the child in medical matters for a limited time.

Parent or guardian

FULL NAME

EMAIL

PHONE

ADDRESS

Child

CHILD'S NAME

DATE OF BIRTH

BLOOD GROUP

ALLERGIES AND CONDITIONS

REGULAR MEDICINES

CHILD'S DOCTOR

DOCTOR PHONE

HEALTH INSURANCE NO.

Caregiver

FULL NAME

EMAIL

PHONE

ADDRESS

RELATIONSHIP TO CHILD

ID (AADHAAR / PASSPORT LAST 4)

Authority

FROM

UNTIL

The caregiver may consent to

- ○ Routine and emergency care
- ○ Emergency care only

- The caregiver will try to contact the parent before any non-emergency treatment.
- This authority does not cover elective surgery, or any decision the parent has excluded below.
- The parent may cancel this authorisation at any time by telling the caregiver and the treating doctor.

EXCLUSIONS OR WISHES

Parent or guardian

SIGNATURE

PRINTED NAME

DATE

Caregiver

SIGNATURE

PRINTED NAME

DATE