**Child Medical Consent Form for Grandparents PDF**

**Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_**

**Child’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_**

### **Grandparent Information**

**Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Relationship to Child: ☐ Maternal Grandparent ☐ Paternal Grandparent**

### **Medical Authorization**

**I, [Parent/Guardian Name], authorize my child’s grandparent [Grandparent’s Name] to:
☐ Make medical decisions in case of emergency
☐ Consent to routine medical care
☐ Approve vaccinations and treatments**

### **Medical Information**

**Primary Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Doctor’s Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### **Known Medical Conditions**

**☐ Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
☐ Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
☐ Chronic Illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This authorization is valid from \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_.**

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_**