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: ____ / ____ / _____