St. Hope Foundation
Authorization for Non-Parent to Consent to Care

I am the legal guardian/ parent of:

_____	_____
Patient's Name	Date of Birth
_____	_____
Patient's Name	Date of Birth
_____	_____
Patient's Name	Date of Birth
_____	_____
Patient's Name	Date of Birth

I authorize the following persons to seek medical care for the above listed child(ren):

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

This authorization permits the above-named persons to consent for:

_____ Medical care _____ Labs _____ Vaccinations

_____ Antibiotic injections _____ Prescriptions

This authorization will remain in force until revoked in writing by me. I hereby attest that I have the legal authority to delegate my authority to consent for care, and that no legal agreement prevents me from delegating authority.

_____	_____
Parent/Guardian Signature	Date

_____
Printed Name