



## Temporary Medical/Dental Consent Form

Date:

Legal Guardian Name:

Address:

Email Address:

Phone Number:

To Whom It May Concern:

I am the parent of \_\_\_\_\_, (Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_) and I do hereby give my permission to and appoint \_\_\_\_\_ as temporary guardian of my minor child during the time period \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_ only to make any and all necessary decisions about my child's health care. Said temporary guardian(s) shall have all of the same rights to choosing and authorizing medical/dental treatment for my child during this time period as I have as a parent.

Sincerely,

Signature: \_\_\_\_\_