Medical Proxy Authorization for Minor

Date: _____

To Whom It May Concern,

I, **[Your Name]**, the undersigned, am the parent/guardian of **[Minor's Name]**, born on **[Minor's Date of Birth]**. In the event that I am unavailable or unable to make medical decisions regarding the health care of my child, I hereby designate and authorize **[Proxy's Name]**, residing at **[Proxy's Address]**, to act on my behalf.

This authorization includes the ability to make decisions about medical treatment, including but not limited to, consent for examinations, procedures, and the administration of medications as necessary.

This authorization is effective from **[Start Date]** until **[End Date or Indefinitely]**, unless revoked in writing by me.

Signed,

[Your Signature]
[Your Printed Name]
[Your Address]
[Your Phone Number]
[Your Email]

Witnessed by:

[Witness Name]
[Witness Signature]
[Witness Address]
[Witness Phone Number]