Child Medical Decision-Making Authorization Letter

Date: _____

To Whom It May Concern,

I, **[Parent/Guardian Name]**, am the parent/legal guardian of **[Child's Name]**, born on **[Child's Birth Date]**. I am writing to grant authorization for medical decision-making regarding my child to the following individual:

[Authorized Person's Name]
Relationship to Child: **[Relationship]**
Contact Number: **[Contact Number]**

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

I understand that this individual will have the authority to make medical decisions on behalf of my child while I am unavailable. This includes but is not limited to:

- Seeking medical treatment
- Signing medical consent forms
- Making decisions regarding emergency care

By signing below, I confirm that I am the legal guardian of **[Child's Name]** and that I provide this authorization willingly.

Signature: _____
Printed Name: **[Parent/Guardian Name]**
Date: _____

Witness Signature: _____
Printed Name: _____
Date: _____

Thank you for your attention to this matter.

Sincerely,

[Parent/Guardian Name]
Address: **[Address]**
Phone Number: **[Phone Number]**