

**District of Columbia
MEDICAL CONSENT AUTHORIZATION FORM**

1. *[Choose the one below that best fits your situation.]*

_____ I am the parent of the child(ren) listed below and there are no court orders now in effect which would prohibit me from exercising the power that I now seek to convey.

OR

_____ I am the legal guardian or custodian of the child(ren) by court order *[Attach a copy of the court order if it is available to you.]* and there are no other court orders now in effect which would prohibit me from exercising the power that I now seek to convey.

2. I am temporarily entrusting to _____,
an adult who resides at _____,
the care of the following child(ren):

Name	Date of Birth	Name	Date of Birth
Name	Date of Birth	Name	Date of Birth

- 3. The caregiver named above may consent to medical, dental, surgical and/or mental health diagnosis and treatment for the child(ren).
- 4. I am giving this consent freely and knowingly in order to provide for the child(ren) and not due to pressure, threats, or payments by any person or agency.
- 5. Upon notification of intent to revoke, there shall be a period of _____ hours before revocation takes effect. Notification of intent to revoke by the parent, legal guardian or legal custodian must be in writing.

[put a line through those provisions that are not applicable]

I hereby swear or affirm that the above statements are true, under penalty of law.

Signature of parent, legal guardian or legal custodian

Date