Temporary Medical Guardianship

To Whom It May Concern:

During my absence the following person(s) will be caring for my child/children:

PERSONS RESPONSIBLE FOR THE CARE OF MY CHILDREN DURING THE TIME PERIOD LISTED BELOW:

Name: _____ / _____
Name Relationship

Name: _____ / _____
Name Relationship

CHILDREN'S INFORMATION:

Name/ DOB: _____

Name/DOB: _____

Name/DOB: _____

I give permission for the person(s) listed above to sign for any medical treatment deemed necessary.

LEGAL GUARDIAN INFORMATION:

Name: _____

Contact number or information where you can be reached, if there is an emergency during your absence_____

Time period this "TEMPORARY MEDICAL GUARDIANSHIP" is in effect:

_____ / _____
Start Date End Date

_____
Signature of Legal Guardian Date
Original signature required

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Sworn to and subscribed before me on: _____
Date

_____
Notary Public

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Temporary guardian should keep this original with them at all times. Our office will keep a copy in your child's medical record. Questions Call Garden City Pediatrics at 978 927-4980