

Caregiver's Authorization Affidavit

Use of this affidavit is authorized by Part 1.5 (commencing with Section 6550) of Division 11 of the California Family Code.

Instructions: Completion of items 1 - 4 and the signing of the affidavit is sufficient to authorize enrollment of a minor in school and authorize school-related medical care. Completion of items 5-8 is additionally required to authorize any other medical care. **Print clearly.**

The minor named below lives in my home and I am 18 years of age or older.

1. Name of minor: _____.
2. Minor's birth date: _____.
3. My name (adult giving authorization): _____.
4. My home address (street, apartment number, city, state, zip code):

_____.
5. I am a grandparent, aunt, uncle, or other qualified relative of the minor (see page 2 of this form for a definition of "qualified relative").
6. Check one or both (for example, if one parent was advised and the other cannot be located):
 - I have advised the parent(s) or other person(s) having legal custody of the minor of my intent to authorize medical care, and have received no objection.
 - I am unable to contact the parent(s) or other person(s) having legal custody of the minor at this time, to notify them of my intended authorization.
7. My date of birth: _____.
8. My California's driver's license or identification card number: _____.

Warning: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: _____ Signed: _____

Non-family

Authorization for Adult to Act as Custodial Parent

I/we, _____ and _____
Name Name
of _____, _____, do hereby state that I/we
County State
are the natural parent(s), legal guardian(s) having legal custody of _____
Child's Name
_____ a minor, age _____, born _____, who resides with me/us at

Address City Zip
I/we authorize _____, an adult, who resides at

Address City County State

to act on my/our behalf in all school matters such as, but not limited to, signing absence verifications, approving field trips, acknowledging notifications, and signing other authorizations.

Dated this _____ day of _____, 20____
Day Month Year

Signature of Parent of Guardian Expiration

Child's doctor _____ Child's allergies, if any _____

Parent's doctor _____ Medicines child is taking _____

Choice of specialist's _____

Natural parent (s), legal guardian (s) having legal custody of _____
Child's Name

Note

It is strongly recommended that this form be signed and notarized prior to accepting.

Temporary Custody

Temporary Custodian to Act on Behalf of Parent

For many reasons children may reside temporarily with people other than their natural parents. This happens when there is an illness in the family, parents taking vacations, or various other reasons.

If parents are gone for a short period of time, and can be contacted in case of emergencies, the problems created for school personnel are minimal. However, parents should always be advised it is wise to have something in writing, which will give authority to the caretaker to make decisions for the minor on behalf of the parents in case of an accident or act on behalf of the parents in other school related matters.

A form such as the following may be acceptable authorization for treatment by doctors or hospitals:

Authorization to Consent to Medical Treatment for Minor Child

I/we _____ and _____
Name Name
of _____, do hereby state that I/we are the natural
County State
parent(s), legal guardian(s) having legal custody of _____, a minor,
Child's Name
age _____, born _____, who resides with me/us at _____
Address
City Name, I authorize _____, an adult, who resides
City Name
at _____, an adult, who resides
Address City County State

To consent to an x-ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state (s) of _____ when the need for such treatment is immediate, and when efforts to contact me (us) are unsuccessful.

Dated this _____ day of _____, 2____.

Signature of parent or guardian _____ Expiration date _____

Child's doctor _____ Child's allergies, if any _____

Parent's doctor _____ Medicines child is taking _____

Choice of specialist's _____ Date of last tetanus shot _____

Accident/Health insurance information _____