Name of Legal Guardian
Address of Legal Guardian
City, State, Zip Code

DATE

RE: Medical Consent

To Whom It May Concern:

I, [Name of Legal Guardian], am the lawful guardian of the female child named below. I give permission and consent to [Name, Address and Phone Number of Grandparents] to authorize medical treatment for [Full Name of Child] and date of birth. This permission is granted from [DATE] and will expire on [DATE].

Signature Of Legal Guardian DATE
Printed Name of Legal Guardian

Signature of Witness or Notary (if required by the state) DATE
Printed Name of Witness