



Custody/Medical Decision-Making Form

Information of Responsible Person(s)

Name _____ DOB _____
Name _____ DOB _____
Street Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work _____
Email _____ Employer _____

Who are your responsible for?

Legal Name of Child	Date of Birth	How are you related?

Emergency Contact Information (local person other than parent or guardian):

Name _____ Relationship _____
Home Phone _____ Cell Phone _____ Work _____

Others authorized to bring children in and make medical decisions:

1. _____
2. _____
3. _____

Is there any legal paperwork that the office needs to understand who has rights to information for the patient(s) and/or medical decision making for the patient(s)? If so, please provide the needed documentation. _____

Parent/Guardian Signature

Date

Name