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| Temporary Guardian Form |
|  |
| **Child** |
| Last Name: |  | First Name: |  | Middle Initial: |  |
| Date of Birth: |  |  Gender: |  | Age: |
|  |
|  |
| **Doctor’s Information** |
| Doctor’s Name: |  |
| Clinic Address: |  |
| Office Phone Number: |  | Emergency Phone Number: |  |
| Medical Insurer/Health Plan: |  | Policy #: |  |
| Treatment that the child is currently receiving: |
|  | Start Date: |  |
| Treatment that the child has previously received: | Start Date: |  |
|  | End Date: |  |
| Allergies to medication: |  |
| Other allergies: |  |
| Other medical information: |
|  |
|  |
|  |
| **Parent(s)/Legal Guardian(s)** |
| **Parent #1:** |
| Last Name: |  | First Name: |  | Middle Initial: |  |
| Address:  |  |
| Home Phone Number: |  | Work Phone: |  |
| Cell Phone: |  | Pager: |  |
| Email: |  |  |  |
| Additional Contact Information: |  |
|  |
| **Parent #2:** |
| Last Name: |  | First Name: |  | Middle Initial: |  |
| Address:  |  |
| Home Phone Number: |  | Work Phone: |  |
| Cell Phone: |  | Pager: |  |
| Email: |  |  |  |
| Additional Contact Information: |  |
|  |
| **Temporary Guardians** |
| **Temporary Guardian #1:** |
| Name: |  |
| Address:  |  |
| Home Phone Number: |  | Work Phone: |  |
| Cell Phone: |  | Pager: |  |
| Email: |  |
| Additional Contact Information: |  |
|  |  |
| **Temporary Guardian #2:** |
| Name: |  |
| Address:  |  |
| Home Phone Number: |  | Work Phone: |  |
| Cell Phone: |  | Pager: |  |
| Email: |  |
| Additional Contact Information: |  |
|  |

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| **AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)** |
|  |
| I do hereby swear that I have legal custody of the aforementioned minor child.  |
|  |
| I grant my authorization and consent for |  | to: |
|  Temporary Guardian |
| □ House, shelter, transport and feed the aforementioned minor child. |
| □ Seek medical attention for the child, including contacting medical personnel and transporting |
|  child to the necessary clinic or hospital. To issue consent for any medical procedure, transfusion, |
|  medication, treatment or care diagnosed and administered by any licensed physician, surgeon, |
|  dentist, or medical personnel. |
| □ Make decisions on behalf of the minor child’s upbringing, discipline, education, extracurricular |
|  activities, religious education and dietary needs. |
|  |
| Payment Plan for housing, food, medical care, tuition, clothing, miscellaneous: |  |
|  |
|  |
| This temporary guardianship is authorized to begin the |  | day of |  | 20 |  |  |
| and will cease to be in effect on the |  | day of |  | 20 |  |  |
|  |
| Signed this |  | day of |  | 20 |  |  |
|  |
|  |
|  |  |  |
| Parent #1’s Signature |  | Temporary Guardian #1’s Signature |
|  |
|  |
|  |  |  |
| Parent #2’s Signature |  | Temporary Guardian #2’s Signature |
|  |  |
|  |
| **CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC** |
|  |
| STATE OF |  |
| COUNTY OF |  |
|  |
| This document was acknowledged before me on  |  | by |
|  |  |
|  |
|  |
|  |  |
| (Signature of Notarial Officer) |  |
|  |
| Notary Public for the State of |  |  |
| My commission expires: |  |  |