DESERT PEDIATRICS
Temporary Medical Guardianship

To Whom It May Concern:

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

PERSON(S) RESPONSIBLE FOR THE CARE OF MY CHILDREN DURING THE TIME PERIOD LISTED BELOW:

Name: ______________________________ / ______________________________
Last Name First Name Middle Name Relationship to you

Name: ______________________________ / ______________________________
Last Name First Name Middle Name Relationship to you

CHILDREN'S INFORMATION:

Name: ______________________________ / ______________________________
Last Name First Name Middle Name Date of Birth

Name: ______________________________ / ______________________________
Last Name First Name Middle Name Date of Birth

Name: ______________________________ / ______________________________
Last Name First Name Middle Name Date of Birth

I give permission for the person(s) listed above to sign for any medical treatment deemed necessary and to obtain medical records which includes PHI.

LEGAL GUARDIAN INFORMATION:

Name: ____
Last Name First Name Middle 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:

______________________________ / ______________________________
Beginning Date Ending Date

____
Signature of Legal Guardian (Original Signature Required) Date

Sworn to and subscribed before me on: ______________________________
Date

____
NOTARY PUBLIC

*Temporary guardian should keep this original with them at all times. Our office will keep a copy in your child's medical record. Questions, please call Desert Pediatrics at (702) 641-2150