



## CAREGIVER'S AUTHORIZATION AFFIDAVIT

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

1. Name of minor: \_\_\_\_\_
2. Minor's Birthdate: \_\_\_\_\_
3. My Name: (adult giving authorization) \_\_\_\_\_
4. My Home Address: \_\_\_\_\_
5. \_\_\_\_\_
6. Length of time minor has resided with the caregiver: \_\_\_\_\_
7. Caregiver's relationship to the minor (grandparent, aunt, uncle or other quality relative of the minor): \_\_\_\_\_
8. 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 intention 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 the time, to notify them of my intended authorization
9. Caregiver's date of birth: \_\_\_\_\_
10. Caregiver Hawai'i driver's license identification card number: \_\_\_\_\_
11. Caregiver's statement of attempts to reach parent(s)/legal guardian of minor:
   
\_\_\_\_\_
   
\_\_\_\_\_
   
\_\_\_\_\_

This declaration does not affect the rights of the minor's parent, guardian, or legal custodian regarding the care, custody, and control of the minor, other than with respect to health care, and does not give the caregiver legal custody of the minor.

The minor's parent or legal custodian may at any time rescind this affidavit of caregiver consent for a minor's health care by providing written notification of the rescission to the appropriate health care professional.

A person who relies in good faith on this affidavit of caregiver consent for a minor's health care has no obligation to conduct any further inquiry or investigation and shall not be subject to civil or criminal liability or to professional disciplinary action because of that reliance.

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

Date: \_\_\_\_\_

Signature of Parent(s)/Legal Guardian: \_\_\_\_\_

Signature of Caregiver: \_\_\_\_\_

Witnessed By: \_\_\_\_\_