RELATIVE CAREGIVER AFFIDAVIT

Before me, the undersigned authority, personally appeared _____ (relative caregiver), who, being by me duly sworn, deposed as follows:

My name is _____, and I am of sound mind and am over
Name of Relative Caregiver

eighteen (18) years of age. My personal information is as follows:

Date of Birth:_____

Address (including city, state, zip code):_____

_____

Contact Information:_____

Driver's License or Identification Card Numbers:_____

I am competent to testify to the following facts and matters:

I am a relative caregiver to _____ whose date of birth is _____.
Name of Student Student's Birthdate

My relationship to the child is _____. The above-mentioned child is living with me
Relationship

at _____ because of the following (describe the
Address

reasons why the child lives with you and any attempts that you have made to advise the parent of your intent to consent to medical treatment or educational services for the child, and any response provided by the parent): _____

_____

_____

_____.

The contact information for the parent, if known, is_____

_____.
Address (including city, state, zip code) and Phone Number

Choose one:

☐ Attached is a signed and dated delegation of authority to me by the parent to consent to educational services or medical treatment.

☐ The reason why I am unable to contact the parent to advise the parent of my intent to consent to educational services or medical treatment for the child is _____

_____.

I attest under penalty of perjury that the named child lives with me, that I am a competent adult and eighteen years of age or older, and that the information provided in the affidavit is true and correct.

I understand that this change in living situation will be forwarded to any and all entities as appropriate e.g., Social Security Administration, Department of Social Services, law enforcement, etc.

I further acknowledge and understand that if the child stops living with me, I shall immediately notify any health care provider or school that has been given the affidavit under this section. This affidavit is invalid immediately upon receipt by the health care provider or school of such notice.

In addition, I acknowledge and understand that this affidavit expires one year after the date the relative caregiver signs the affidavit.

_____ _____

Date Signature of Affiant

THE STATE OF MISSOURI

COUNTY OF _____

I hereby affirm that the above-referenced individual personally appeared before me on this date and affixed his/her signature hereto.

Subscribed and sworn to before me this _____ day of _____, 20_____.

_____

(Notary Seal) Signature of Notary Public

My commission expires: _____