DESIGNATION OF HEALTH CARE SURROGATE

FOR MINOR

I/We, _____ (name/names), the (check the box that applies,) [_____] natural guardian(s) as defined in s. 744.301(1), Florida Statutes; [_____] legal custodian(s); [_____] legal guardian(s) of the following minor(s):

_____,

_____,

_____,

Pursuant to s. 765.2035, Florida Statutes, designate the following person to act as my/our surrogate for health care decisions for such minor(s) in the event that I/we am/are not able or reasonably unavailable to provide consent for medical treatment and surgical and diagnostic procedures:

Name:_____

Address:_____

_____

Phone: _____

If my/our designated health care surrogate for a minor is not willing, able, or reasonably available to perform his or her duties, I/we designate the following person as my/our alternate health care surrogate for a minor:

Name:_____

Address:_____

_____

Phone: _____

I/We authorize and request all physicians, hospitals, or other providers of medical services to follow the instructions of my/our surrogate or alternate surrogate, as the case may be, at any time and under any circumstances whatsoever, with regard to medical treatment and surgical and diagnostic procedures for a minor, provided the medical care and treatment of any minor is on the advice of a licensed physician.

I/We fully understand that this designation will permit my/our designee to make health care decisions for a minor and to provide, withhold, or withdraw consent on my/our behalf, to apply for public benefits to defray the cost of health care, and to authorize the admission or transfer of a minor to or from a health care facility.

I/We will notify and send a copy of this document to the following person(s) other than my/our surrogate, so that they may know the identity of my/our surrogate:

Name:_____

Name:_____

Signed:_____

Date: _____

WITNESSES:

1. Name:_____

   Date: _____

2. Name:_____

   Date: _____