DESIGNATION OF HEALTH CARE SURROGATE
FOR MINOR

I/We, _____NAME/S_____, the ☐ natural guardian(s) as defined in s. 744.301(1), Florida Statutes; ☐ legal custodian(s); ☐ legal guardian(s) [check one] 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 available to provide consent for medical treatment and surgical and diagnostic procedures:

Name: _____NAME_____

Address: _____ADDRESS_____

Zip Code: _____ZIP CODE_____

Phone: _____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: _____NAME_____

Address: _____ADDRESS_____

Zip Code: _____ZIP CODE_____

Phone: _____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.

Signature:_____

Printed Name:_____NAME_____

Date:_____1-1-2000_____

WITNESSES (must be disinterested and not be related or named above):

1._____WITNESS_____

2._____WITNESS_____