DESIGNATION OF HEALTH CARE SURROGATE FOR MINOR

Parent/Guardian Name:_____

Phone:_____

Address:_____

City:_____ State:_____ Zip_____

I/We (name/names_____), the [ ] natural guardian(s); [ ] legal custodian(s);
[ ] legal guardian(s) of the following minor(s):

_____;
Minor Last Name, First Middle Initial Date of Birth

_____;
Minor Last Name, First Middle Initial Date of Birth

_____;
Minor Last Name, First Middle Initial Date of Birth

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:

Surrogate Name: _____

Phone:_____

Address:_____

City:_____ State:_____ Zip_____

Relationship to minor: _____

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.

THIS DESIGNATION OF HEALTH CARE SURROGATE FOR MINOR SHALL TERMINATE ON:

(Please select one of the following)

☐ **THE COMPLETION OF ENCOUNTER WITH MEMORIAL HEALTHCARE SYSTEM MEDICAL STAFF.**

☐ **THE FOLLOWING DATE _____ (FILL IN THE DATE).**

Parent/Guardian Signature: _____ Date: _____
(Print the form and sign it by hand.)

WITNESSES:

Witness 1:_____ Date:_____
(Witness signature)

Witness 2:_____ Date:_____
(Witness signature)

_____☐_____ Interpreter used for _____ language. Interpreter ID Number _____

_____☐_____ Multilingual provider/surgeon provided informed consent in patient's preferred language.

PATIENT/LABEL