Alternate Parties Authorized to Consent for Medical Care for Minor
Designation of Health Care Surrogate for Minor

I/We,_______________ _____________________,

the [ ] natural guardian(s) as defined in s.744.301(1), Florida Statutes;
[ ] legal custodian(s);
[ ] legal guardian(s) of the following minor(s):

____ _______________
Name and U# DOB

____ _______________
Name and U# DOB

____ _______________
Name and U# DOB

Pursuant to s. 765.2035, Florida Statutes, designate the following person unaffiliated with the University of South Florida 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, psychiatric treatment and surgical and diagnostic procedures:

Name (MUST BE 18 years old or older): ____

Address:____
____
____

Home Phone: ________________________
Cell 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 unaffiliated with the University of South Florida as my/our alternate health care surrogate for a minor:

Name (MUST BE 18 years old or older): ____

Address:____

____

____

Home Phone: ________________________
Cell 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, psychiatric 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:_______________________________AND_______________________________

Date:_____________________________________

WITNESSES SIGNATURES :(Must have TWO Witnesses 18 years old or older)

1. Name:____
   Date of Birth: ____

2. Name:____
   Date of Birth: ____