DESIGNATION OF HEALTH CARE SURROGATE FOR MINOR

I, _____, 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 our surrogate for health care and mental health decisions for such minor(s) in the event that I am not able or reasonably available to provide consent for medical treatment, surgical and diagnostic procedures and mental health treatment for the minor(s):

Name: _____

Address: _____

Phone Number: _____

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

Name: _____

Address: _____

Phone Number: _____

I authorize and request all physicians, hospitals, or other providers of medical services to follow the instructions of my 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 fully understand that this designation will permit my designee to make health care decisions for a minor and to provide, withhold, or withdraw consent on 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 will notify and send a copy of this document to the following person(s) other than my surrogate, so that they may know the identity of my surrogate:

Name: _____

Date: _____

WITNESSES:

Signatures of Witnesses:

First Witness		**Second Witness**	
Print Name:	_____	Print Name:	_____
Address:	_____	Address:	_____
	_____		_____
Signature:	_____	Signature:	_____
Date:	_____	Date:	_____