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) [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: _____

Address: _____

City, State, Zip code _____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: _____

City, State, Zip code _____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: _____

Signed: _____ Date: _____

Name: _____

Signed: _____ Date: _____

WITNESSES:

1. _____ Date: _____

2. _____ Date: _____

FAQ – Frequently Asked Questions

For immunizations or routine medical/dental non-emergency care (including ordinary immunizations, blood testing, TB testing, well-child care and ordinary and necessary examination and treatment) which do not requiring surgery, general anesthesia, psychotropic medicines, or any other extraordinary procedures:

A parent or **legal guardian/custodian (someone with a court order if not the parent)** must be **present and authorize the immunization (**or other non-emergency medical or dental treatment)* for a **minor child,** UNLESS:

1. The **minor to receive the service has been EMANCIPATED** by **law**, by **marriage,** or by **court order**.
   -Examples of **emancipation by law** include certain **homeless unaccompanied minors** (if they have the required paperwork declaring them an emancipated minor), a **minor parent of a child**, **who can sign for their own medical care regarding the pregnancy and for care for their child**, and minors for **certain types of medical care (birth control, pregnancy, STD/HIV testing and treatment).; OR**
2. The person present has a **POWER OF ATTORNEY * from the parent or legal guardian**, which expressly authorizes the person present to authorize medical care for the child. **A POWER OF ATTORNEY is NOT just a signed note from the parent**. It is a signed legal document which details the powers it is giving to the other person, the duration of the power (sometimes), and the conditions when the power may be used. It must be **signed by the person with legal authority** (ie, parent or guardian/custodian**) in the presence of 2 witnesses and a notary public. OR**
3. **The person present has a DESIGNATION OF HEALTH CARE SURROGATE FOR TREATMENT OF MINOR CHILD* in their name from the parent or guardian, designating them as a person authorized to obtain the care at issue for the child present. THIS IS THE FORM YOU SENT OUT. This form requires the signature of the parent/guardian and must have been signed in the presence of 2 witnesses, one of which may NOT be to person appointed. OR**
4. If the person present with the child is the STEPPARENT, GRANPARENT, ADULT SIBLING, OR ADULT AUNT OR UNCLE of the child, we can provide immunizations and other care as above IF the child has NOT been committed to the custody of DCF or DJJ, and after **OUR REASONABLE ATTEMPT TO CONTACT THE PARENT is unsuccessful, we can give the care. We must document the reasonable efforts we made to contact the parent in the medical file.**

NOTE: We cannot honor the POA, Designation, or use of any other person if the parent has notified us that they have revoked the documents or do not agree to the specific person obtaining care, regardless of the existence of the document or relationship.

*POAs and SURROGACY forms also generally authorize more significant care, including medically necessary surgery or anesthesia, if within the terms of the document.