

**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: _____

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: _____

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.

Signature: _____

Printed Name: _____

Date: _____

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

1. _____

2. _____