PARENTAL CONSENT FOR TREATMENT & CARE OF MINORS

I,_____ being the parent and/or legal Guardian of the minor age child,
_____ **DOB**_____, have the legal authority to give consent for the treatment of this minor child. I hereby authorize such diagnostic, medical and/or surgical treatment of such minor child as may be considered medically necessary and appropriate, under the circumstances, including emergency treatment, by the health care providers affiliated with North Florida Surgeons, P.A. and anyof its affiliated entities. I agree that treatment may be provided in my absence. In the event I am not available at a time this minor child requires medical care, I give the parties listed below the authority to seek and authorizemedical care.

Consent is only valid if signed and dated by the Parent/Legal Representative.

_____ _____

Signature of Parent/Legal Representative Date

_____

Print Name of Parent/Legal Representative

_____

Legal Authority to Act for Patient (Parent, Guardian, Power of Attorney, Healthcare Surrogate, etc.)

ALTERNATE PARTIES AUTHORIZED TO SEEK MEDICAL CARE FOR MINOR CHILD

1)_____ _____

Print Name Relationship

Work Phone:_____ Home Phone:_____ Initial of LegalGuardian:_____

2)_____ _____

Print Name Relationship

Work Phone:_____ Home Phone:_____ Initial of LegalGuardian:_____

This consent will remain in effect for one year from the date the consent was signed.