UNIVERSITY of SOUTH FLORIDA
Student Success
Student Health & Wellness Center

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 UUl8 years old or older):Tc 0.001 Tw 0.221 0 [(U)0.9221 0S9 0 7(ou21 0 Td Tc 6al94) his

_____

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