

AUTHORIZATION AND CONSENT FOR MEDICAL TREATMENT OF A MINOR CHILD

To: Pediatrics In Brevard, P.A.
134 S. Woods Drive, Rockledge, FL. 32955
1755 W. Hibiscus Blvd., Melbourne, FL. 32901
699 W. Cocoa Beach Cswy., Ste. 401, Cocoa Beach, FL. 32931
7332 Office Park Pl., Ste. 103, Viera, FL. 32940

I, the undersigned parent or legal guardian of _____, a minor child whose date of birth is _____, (“Child”), by this written authorization do hereby authorize and give my consent to Pediatrics In Brevard, P.A., its physicians and their authorized personnel (referred to individually and collectively as “Physicians”) to evaluate and administer medical treatment to my Child in those situations indicated by me below where I am not physically present with my Child.

As initialed below to indicate my consent and/or the delegation of my authority to consent to the medical evaluation, diagnosis and treatment of my Child, I agree to and hereby authorize the following actions by Physicians, until such time as I revoke in writing the authorizations and consents listed below:

_____ I hereby authorize Physicians to see, examine, evaluate and treat (including administration of immunizations and/or lab work) my Child, in accordance with the personal requests of my Child’s family member, _____, who is related to my Child as his or her _____, if I am not present, in accordance with the consent communicated by the above individual to Physicians pursuant to the delegation of my authority granted here, and consistent with the Physicians’ professional judgment of my Child’s medical needs.

FOR CHILDREN 16 YEARS OF AGE OR OLDER:

_____ I hereby authorize Physicians to see, examine, evaluate and treat my Child in accordance with my Child’s personal requests if I am not present, consistent with the Physicians’ professional judgment of my Child’s medical needs.

Nothing herein shall be deemed as my request, direction, authorization or consent for Physicians to administer or deliver any examination, diagnostic testing, treatment or other medical services which Physicians, in their sole professional judgment, deem to be inappropriate in the absence of a parent or not medically necessary.

This document is intended to be a valid authorization and consent pursuant to Florida Medical Consent Law, Florida Statutes 766.103, and shall remain in force until revoked by me in writing.

Parent/Legal Guardian Name (printed)

Date

Signature of Parent/Legal Guardian

Note: If you are acting in the capacity as a court ordered and appointed legal guardian, kindly supply us with a certified copy of the guardianship order evidencing such authority.