Lakeland Regional Health®

AUTHORIZATION FOR MEDICAL TREATMENT

MR#_____

(Consent to Medical Treatment of Unaccompanied Adolescent Minor or Minor Accompanied by Baby Sitter, Friend, Other Family Member, Neighbor or School Official)

Name of Child: _____ DOB: _____

Name of parent(s) or Legal Guardian: _____

Address: _____

I hereby grant permission to any person other than me, such as my baby-sitter, friend, other family member, neighbor, or school official named below, who is caring for the above-named minor during my unavailability, to seek medical care for the above-named minor when he/she finds it necessary.

Parent/Guardian/Custodian can be located at the following address/phone number:

_____

_____

_____

Baby Sitter: _____

Friends: _____

Other Family Members: _____

Neighbors: _____

School Official: _____

I understand that should the above-named minor be brought to Lakeland Regional Health for non-routine medical treatment, an attempt will be made to notify me by telephone. I hereby give my consent to LRH to furnish routine medical treatment and services, including without limitation, ordinary and necessary medical treatment blood testing, preventative care (including ordinary immunizations), tuberculin testing, and well-child care. This consent does not include consent for surgery, general anesthesia, or provision of psychotropic medications.

This permission shall include any circumstance when I am not present, including, but not limited to, when the above-named minor is unaccompanied or when the above-named minor is accompanied by a person other than me, such as my baby-sitter, friend, other family member, neighbor, or school official. I am aware that there are risks associated with the practice of medicine, but that the services provided under this consent do not have a high risk factor.

If there is only one signature below, the undersigned certifies and warrants either (i) that he/she is the above-named minor's sole parent or legal guardian, and has the authority to sign this form without the approval or additional signature of any other person or entity, or (ii) that he/she has the authority designated by statute and/or court order to consent for any and all forms of healthcare for the above-named minor. I agree to be financially responsible for payment of all charges that are not paid by any insurance agency for all medical care and treatment services furnished by LRH. I authorize LRH to bill my insurance on file.

Medical and Insurance Information:

Any Known Allergies: _____

Current Medications: _____

Date of Last Tetanus Booster: _____

Pertinent Medical History: _____

_____

_____

Insurance Company: _____ Policy #:_____

This authorization shall be in effect until revoked in writing by me; if revoked, prior actions ok.

Unaccompanied Adolescent Minor's Affirmation

I, the child named above am an unaccompanied adolescent minor seeking routine medical treatment from LRH. I understand that if I am required to receive treatment that is not routine medical treatment, LRH will have to contact my parent(s), legal guardian(s), or legal custodian(s) to obtain consent for such treatment.

WITNESS:

_____
Signature

Print Name: _____

ADOLESCENT MINOR:

_____
Signature

Print Name:_____

WITNESS:

_____
Signature

Print Name:_____

PARENT(S)/LEGAL GUARDIAN(S):

_____
Signature

Print Name:_____

_____
Signature

Print Name:_____

_____
Signature

Print Name:_____

STATE OF FLORIDA,
COUNTY OF POLK.

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____,

by _____, ☐ who is personally known to me or ☐ who has produced a Florida driver's license as identification, and who did not take an oath.

(Affix Notary Seal)

_____

Print Name: _____

NOTARY PUBLIC, State of Florida

My Commission Expires: _____