



Charlie Crist
Governor

Ana M. Viamonte Ros, M.D., M.B.A.
Secretary, Department of Health

DeSoto County Department of Health

Mary Kay Burns, B.S.N., M.B.A.
Administrator

34 South Baldwin Avenue
Arcadia, Florida 34266

AUTHORIZATION TO TREAT A MINOR CHILD

To Whom It May Concern: I, the undersigned, as parent or legal guardian for:

Child's Name _____ Date of Birth _____

do hereby grant authority to the following individual to give informed medical consent including, but not limited to, arranging for and/or authorizing consultation, evaluation, treatment, including medication and/or vaccine administration, for the above named minor child/children.

Name _____ Phone _____

Address _____

Relationship _____

This authorization shall remain in effect for six months from the date signed below.

Signed this _____ day of _____, 20_____

Parent/Guardian _____

Witness _____

STATE OF FLORIDA/DESOTO COUNTY

Before me, the undersigned authority appeared the above parent/guardian, who being duly identified signed this instrument in my presence this _____ day of _____, 20_____.

Notary Public _____

My commission expires: _____