AUTHORIZATION FOR TREATMENT

(THIS FORM MUST BE NOTARIZED)

I/We, the undersigned, parent(s)/Guardian(s) of _____, do hereby authorize the school district, it's staff, our representatives, as agent(s) for the undersigned to consent to a X-ray examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care that is deemed advisable by, and is to be rendered under the general supervision of any physician, physician extender, and surgeon licensed under the provisions of the Medicine Practice Act on the Medical Staff of any Hospital or medical clinic whether such diagnosis or treatment is rendered at the office of said physician or said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, assessment at time of injury treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment deem advisable; and to include emergency or urgent care as deemed necessary by supervising personnel.
The authorization is given pursuant to the provisions of **Section 456.057, Florida Statutes,** which allows Parent(s) or Guardian(s) to authorize any adult to consent to medical or dental treatment as stated in the above paragraphs).

This authorization shall remain effective from the date below, unless sooner revoked in writing delivered to said agent(s).

Signed _____ Dated_____

Print Name _____
(Parent or Legal Guardian)

STATE OF FLORIDA
County of _____
The foregoing instrument was acknowledged before me this
_____ Day of _____ 20_____
By _____
❒ PERSONALLY KNOWN TO ME
❒ PRODUCED AS IDENTIFICATION

_____
Type of identification

Notary Public
Affix Notary Seal

_____
Notary Public, State of Florida at Large