# MEDICAL CONSENT FORM

**MEDICAL CONSENT FORM**

**Date** _____

**To Whom It my Concern:**

**[I/We],** _____ **and** _____**, are leaving our**
**Father/Legal Guardian's Name** **Mother/Legal Guardian's Name**

**child/children** _____
**Child/Children's name**

**in the care of** _____ **.**
**Responsible Party's Name**

**In the event of an emergency or accident involving our child/children,**

_____
**Responsible Party's Name**

**has our permission to make any decision or sign any medical consent forms necessary for treatment.**

**We can be reached at the following number:** _____

_____ _____
**Father/Legal Guardian's Signature** **Mother/Legal Guardian's Signature**

STATE OF FLORIDA COUNTY OF _____

The foregoing instrument was acknowledged before me this _____day of _____, 20___, by (name of person acknowledging)_____.

(NOTARY SEAL) (Signature of Notary Public-State of Florida)
(Name of Notary Typed, Printed, or Stamped)

❑ Personally Known OR ❑ Produced Identification
Type of Identification Produced _____