



Designation Of Surrogate Health Care Decision Maker
MINOR CHILD

I, _____
(insert parent/legal guardian's name)

being the parent and/or legal guardian of _____
(insert minor child's full name)

hereby designate and empower the following adult person _____
(insert surrogate's name) to give informed consent

for medical treatment and surgical and diagnostic procedures, including use of anesthesia, on behalf of my minor child. I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on behalf of my minor child, and to authorize my minor child's admission to or transfer from a health care facility.

I further affirm that this designation is not being made a condition of treatment or admission to a health care facility.

I have read this form and certify that I understand its contents and authorize this consent to remain valid until: _____

DATE
(Valid until above date otherwise if left blank expires after 30 days)

Minor's Name: _____
Address: _____
Phone: _____

Signature of Parent/Guardian _____ Date _____ Emergency Phone Number _____

To be valid this form must either be witnessed by two non-relatives of the signatory or be notarized.

Witnesses: (Witness should not be a spouse or blood relative of the signatory.)

1. _____
SIGNATURE DATE PRINT NAME

2. _____
SIGNATURE DATE PRINT NAME

STATE OF OHIO)
COUNTY OF _____) ss

On this _____ day of _____, 20____, before me, the undersigned Notary Public, personally appeared and, proved to me on the basis of satisfactory evidence to be the person whose name is subscribed above, and acknowledged that he/she executed it.

Witness my hand and official seal. _____
Notary Public

Minor Child's Medical Information

Name of Minor: _____
Date of Birth: _____
Allergies: _____
Medications: _____
Medical History: _____
Date of last Tetanus: _____
Physician: _____
Dentist: _____
Insurance Co. & Policy No.: _____

