



## Authorization for Third Party Treatment to Consent to Treatment of Minor/Adult Lacking Capacity to Consent

**Must be Notarized**

In case of emergency, I understand in the event I cannot be reached, I, the undersigned parent(s)/person having legal custody of or being legal guardian of \_\_\_\_\_, a minor, do hereby authorize The officers, board members, program directors, coaches, or other representatives of the Lake County Rowing Association (LCRA) as agent(s) for the undersigned to consent to any x-ray examination, and the anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, 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, treatment or agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which physician, meeting the requirements of this authorization, may, in the exercise of his/her best judgment deem advisable. I hereby authorize any hospital that provided treatment to the above named minor to surrender physical custody of such minor to my above named agent(s) upon completion of treatment. These authorizations will remain in effect for one (1) year from date notarized unless revoked in writing and delivered to said agent(s).

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_  
*(sign only in the presence of a notary)*

State of Florida, County of \_\_\_\_\_ . The foregoing instrument was

Acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_,

by \_\_\_\_\_, who is personally known to me or produced  
\_\_\_\_\_ as identification.

\_\_\_\_\_  
Date Commission Expires

\_\_\_\_\_  
Notary Public