PARENTAL AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR

I, _____ (print your name), am the parent or legal guardian having custody of _____ (print minor's name), a minor child. As such parent or legal guardian, I hereby authorize and appoint HABITAT FOR HUMANITY OF BREVARD COUNTY, INC., a Florida nonprofit corporation as my agent to act for me with respect to the Volunteer and in my name in any way that I could act in person to make any and all decisions for me with respect to the Minor Child concerning the Minor Child's personal care, medical treatment, hospitalization and health care, and to require, withhold or withdraw any type of medical treatment or procedure, including without limitation, x-ray examination, anesthetic, medical or surgical diagnosis of treatment which may be rendered to the Minor Child under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state in which treatment is sought. My agent shall each have the same access to the Minor Child's medical records that I have, including the right to disclose the contents to others. I expressly acknowledge and agree that this authorization is intended to be as broad and inclusive as permitted by the laws of the State of Florida, and that this authorization shall be governed by and interpreted in accordance with the law of the State of Florida.

Dated this _____ day of _____, 20____.

_____ **PARENT/GUARDIAN (Signature)**

_____ **PARENT/GUARDIAN (print)**

_____ **WITNESS (signature)**

_____ **WITNESS (print)**

_____ **EMERGENCY PHONE**

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