**Child Medical Consent Form Florida**

**Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_**

### **Child’s Information**

**Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### **Parent/Guardian Details**

**Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Relationship to Child: ☐ Parent ☐ Legal Guardian  
Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### **Authorized Caregiver Information**

**Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Relationship to Child: ☐ Teacher ☐ Family Friend ☐ Babysitter ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### **Medical Consent Statement**

**I, [Parent/Guardian Name], authorize [Authorized Caregiver] to obtain necessary medical treatment for my child [Child’s Name] in the event of illness or emergency.**

**☐ I authorize emergency medical procedures  
☐ I authorize dental treatment  
☐ I allow the administration of prescribed medications**

### **Health Insurance Information**

**Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This form complies with Florida state laws and remains in effect until revoked in writing.**

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_**