Small World Pediatrics, P.A.

2527 Windguard Circle, Ste 102, Wesley Chapel, FL 33544
Phone (813) 907-8001 • Fax (813) 907-5744

AUTHORIZATION OF MEDICAL DECISION MAKING

Patient Name: _____ Date of Birth: _____ /_____ /_____

I, _____ (Parent/Guardian) acknowledge that I have authorized the following individual(s) to make medical decisions regarding the medical care my child/ward _____ (Patient's Name) receives at Small World Pediatrics. This includes, but is not limited to: obtaining history, performing a physical examination, collecting bodily fluid samples for testing, administration of medications for treatment, injections for treatment, vaccines for illness prevention, and treatment plan in general.

Authorized Person(s) Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____
_____	_____

Parent/Guardian Signature: _____ Date: _____ /_____ /_____

Notary: (If signed while not in the presence of Small World Pediatrics staff)

_____ _____
(Notary Name) (Notary Signature)

_____ /_____ /_____
(Notary Stamp) (Date of Commission Expiry)

OR

I acknowledge that I have been given this form and have declined to authorize any other person(s) to make medical decisions for my child.

_____ _____ /_____ /_____
Parent/Guardian Signature Date Signed

_____ _____ /_____ /_____
Received By (Employee Initials) Date Received by Small World Pediatrics

Rev. 09/19/15