12111 PANAMA CITY BEACH PARKWAY
PANAMA CITY BEACH, FL 32407

INFORMED CONSENT AND MEDICAL AUTHORIZATION FOR A MINOR

I hereby acknowledge that I have been informed that medical care and treatment received at Florida Wellness Group will be provided by Physicians, Mid-Level Practitioners and the staff at Florida Wellness Group.

In view of the foregoing, I hereby authorize and consent to any and all medical care and treatment for the minor named below which is deemed necessary and appropriate by a physician licensed in the State of Florida on, or on the behalf of, Florida Wellness Group. This consent includes but is not limited to medical and surgical intervention and elective as well as emergency care.

Child's Name:_____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____

Date:_____

Witness Signature:_____