CONSENT BY PROXY FOR NONURGENT PEDIATRIC CARE FORM

CHART # ____________

<table>
<thead>
<tr>
<th>CHILD’S FULL NAME</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I AUTHORIZE THE FOLLOWING INDIVIDUALS TO SEEK MEDICAL CARE FOR MY CHILDREN IN MY ABSENCE. THIS AUTHORIZES CARE AT THE OFFICE, MEDICAL ADVICE OVER THE PHONE AND AT AFFILIATED HOSPITALS, ARNOLD PALMER HOSPITAL, FLORIDA HOSPITAL NORTH ALTAMONTE SPRINGS, FLORIDA HOSPITAL SOUTH ORLANDO AND SOUTH SEMINOLE HOSPITAL LONGWOOD.

LIMITATIONS

IDENTIFY ANY LIMITATIONS ON THE KIND OF MEDICAL SERVICES FOR WHICH THIS CONSENT BY PROXY IS GIVEN. IF NONE, STATE “NONE”.

________________________________________

IDENTIFY ANY LIMITATIONS ON THE TIME FRAME FOR WHICH THIS CONSENT BY PROXY IS GIVEN. IF NONE, STATE “NONE”.

________________________________________

*PLEASE LIST CONSENT BY PROXY, OTHER THAN MOM OR DAD*

NAME: __________________________

RELATIONSHIP TO PATIENT:________________________

NAME: __________________________

RELATIONSHIP TO PATIENT:________________________

NAME: __________________________

RELATIONSHIP TO PATIENT:________________________

SIGNATURE OF PARENT: __________________________

DATE: __________________________

Miles M. Landis, M.D.
Karen J. Hillock, M.D.
Mark D. Roque, M.D.
Robert H. Chong, M.D.
Thomas J. Alber, M.D.
Dennis R. Gross, M.D.

Kay P. Carey, MSN, A.R.N.P.
Dawn P. Ellis, PA-C, MHP
Cynthia M. Walker, MSN, A.R.N.P.
Kerri Knoll, MSN, A.R.N.P.
Jill Kernegay, MSN, A.R.N.P.