LIMITED POWER OF ATTORNEY
FOR CARE OF MINOR CHILD(REN)

KNOW ALL PERSONS BY THESE PRESENT:

That I/We, _____, adult resident citizen(s) of _____ County, State of _____, hereinafter "Natural Guardian(s)", residing at _____ _____, _____, state the following:

1. Natural Guardian(s) is/are the parent(s) of the following Minor Child(ren):

Name	Age	[illegible]
_____	_____	_____
_____	_____	_____
_____	_____	_____

Known allergies:

Name of Child	Known Allergies
_____	_____
_____	_____
_____	_____

2. Natural Guardian(s) have made, constituted and appointed, and by these presents do make, constitute and appoint, _____ (name), _____ (address-city-state), as our/my true and lawful Attorney-in-Fact, hereinafter "Attorney-In-Fact", to act with the limited powers, as specified herein, in regard the Minor Children named above. As such, the Attorney-in-Fact shall be the Attorney-in-Fact for Natural Parent(s) and for said Minor Child(ren).

3. The Attorney-in-Fact named in paragraph two (2) shall have the following powers in regard to the health, education and general welfare of the Minor Child(ren) named in paragraph one (1), to wit:

   (a) To act for and on behalf of the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is

deemed advisable by, and is to be rendered under the general or specific supervision of any physician and surgeon licensed under the provision of the Medical Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital, during all times that the Minor Child(ren) is/are in the presence of said Attorney-in-Fact. It is understood that this power is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid Attorney-in-Fact to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his or her best judgment may deem advisable; and

(b) To do and perform any and all acts necessary or required to be done which the natural parent would perform in reference the education of said Minor Child(ren). It is expressly the intent of the Natural Guardian(s) that the Attorney-in-Fact is hereby given wide discretion in education matters and that all educational institutions shall recognize and follow the instructions of the Attorney-in-Fact in regard to the education of such Child(ren); and

(c) To perform and provide discipline for said Child(ren) as if said Attorney-in-fact were the Natural Guardian of said Minor Child(ren); and

(d) To perform all acts as Natural parent in reference to any and all legal matters necessary or proper for the custody, care and education of said Minor Child(ren); and

(e) Hereby giving unto our aforesaid Attorney-in-Fact to execute, acknowledge and deliver any instrument under seal or otherwise, and to do all things necessary to carry out the intent hereof, hereby granting unto said Attorney-in-Fact full power and authority to act in and concerning the premises as fully and effectually as the Natural Parent(s) may do if personally present, limited, however, to the purpose for which this limited power of attorney is executed. The Attorney-in-Fact may execute any and all such documents or other papers in the following form: "_____, Attorney-in-Fact for {name applicable Child}, a Minor Child".

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY CHILD'S PHYSICAL OR MENTAL HEALTH.

A. General Grant of Power and Authority. Subject to any limitations in this Directive, my agent has the power and authority to do all of the following: (1) Request, review and receive any information, verbal or written, regarding my child's physical or mental health including, but not limited to, medical and hospital records; (2) Execute on my behalf any releases or other documents that may be required in order to obtain this information; (3) Consent to the disclosure of this information; and (4) Consent to the donation of any of my child's organs for medical purposes.

B. HIPAA Release Authority. My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my child's individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through 164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to my child, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my child's individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my child's health care providers to restrict access to or disclosure of my child's individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my child's health care provider.

4. The Natural Parent(s) hereby release the Attorney-in-Fact from any and all liability and damages of any kind or character which may arise from the performance of the duties herein provided in consideration for the Attorney-in-Fact's acceptance of the duties specified herein.

5. This Power of Attorney and the powers of the Attorney-in Fact shall begin on the _____ day of _____, 20_____ and remain effective through the _____ day of _____, 20____, unless sooner revoked in writing by the Natural Parent(s).

6. This Power of Attorney may be terminated or revoked by the Natural Parent(s), and if two, by any one of them, by delivery of a written Notice of Termination to the Attorney-in-Fact at any time.

7. Any person may rely upon the continued effectiveness of this Power of Attorney and the continued powers of the Attorney-in-Fact, unless or until such person has received actual notice of the termination of same.

8. Natural Parent(s) further declare that any act or thing lawfully done hereunder and within the powers herein stated by said Attorney-in-Fact shall be binding on the Natural Parent(s) and their heirs, legal and personal representatives and assigns.

IN WITNESS WHEREOF, I/We have hereunto set my/our hand and seal this the _____ day of _____, 20____.

_____

Witnesses:

_____

Name and Address

_____

_____

_____

_____

Name and Address

_____

_____

_____

_____

Witness:

_____

Name and Address

_____

_____

_____

_____

Name and Address

_____

_____

_____

STATE OF _____
COUNTY OF _____

PERSONALLY came and appeared before me, the undersigned authority in and for the jurisdiction aforesaid, the within named _____, who acknowledged to me that she/he/they signed, executed and delivered the foregoing Power of Attorney on the day and year therein mentioned.

GIVEN under my hand and official seal of office, this the _____ day of _____, 20__.

_____
NOTARY PUBLIC

My Commission Expires:
_____

Acceptance by Attorney-in-Fact

I, _____, hereby accept the duties, powers responsibilities contained in the above and foregoing Power of Attorney.

DATED this the _____ day of _____, 20__.

_____

INFORMATION SHEET
Complete one for Each Child

Date: _____

Home Phone _____Work Phone _____

Other phone number _____

Other Emergency Contact _____ Phone _____

Family Doctor _____ Phone _____

Insurance Co. _____ If [illegible] check ____

Insurance Policy Name and # _____

Known Medical Conditions

_____

_____

_____

Medications? _____

Allergies? _____

Last Tetanus Immunization? _____

Will You Allow Blood Transfusions? Yes____ No____

Other_____

Parent: _____
Signed