NON-DURABLE POWER OF ATTORNEY FOR PHYSICAL AND HEALTH CARE OF MINOR CHILD

THE POWERS YOU GRANT BELOW WILL TERMINATE IF YOU BECOME DISABLED OR INCOMPETENT

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROUD AND SWEEPING. THEY ARE EXPLAINED IN THE UNIFORM STATUTORY FORM POWER OF ATTORNEY ACT. IF YOU HAVE ANY QUESTIONS ABOUT THESE POWERS, OBTAIN COMPETENT LEGAL ADVICE. YOU MAY REVOKE THIS POWER OF ATTORNEY IF YOU LATER WISH TO DO SO.

POWER OF ATTORNEY made this _____ day of _____, _____.

I,_____, residing at _____, as the sole custodial parent of _____ [Child Name] hereby appoint: _____

_____

(insert the name and address of the person appointed)

as my attorney-in-fact (my "agent") to act for and in my name (in any way I could act in person) to provide for the temporary care of my child and to make any and all decisions for me concerning my child, _____(child's name) in regards to his personal care, medical treatment, hospitalization and health care to require, withhold or withdraw any type of medical treatment or procedure, even though my child's death may ensue. My agent shall make every effort to prolong to the greatest extent possible, the chances of my child to recover without regard to my child's condition or the costs of procedures until such time as I can be contacted and provide directions regarding life-support, food and hydration.

My agent shall have the same access to my child's medical records that I have, including the right to disclose the contents to others.

The powers granted above shall not include the following powers or shall be subject to the following rules or limitations:

- My agent shall not have the power or authority to authorize the termination of life-support, food or hydration.

This power of attorney shall become effective on the _____ day of _____, _____. While this power of attorney is in effect, I will be _____ _____, and can be located by _____.

This power of attorney shall terminate as soon as I resume the physical care of my child or as soon as I direct medical care personnel or other authorities of the termination of this power of attorney.

If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I name the following (each to act alone and successively, in the order named) as successors to such agent,

_____ *[First Successor]* and
_____ *[Second Successor]*.

For the purposes of this paragraph, a person shall be considered incompetent if and while the person is a minor or an adjudicated incompetent or disabled person or the person is unable to give prompt and intelligent consideration to health care matters, as certified by a licensed physician.

I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Signed this the _____ day of _____, 20____

_____
(Your Signature)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

STATE OF _____

COUNTY OF_____

This document was acknowledged before me on _____ [Date] by

_____ [name of principal].

[Notary Seal, if any]:

_____
(Signature of Notarial Officer)

Notary Public for the State of

_____

My commission expires:

_____

ACKNOWLEDGMENT OF AGENT

BY ACCEPTING OR ACTING UNDER THE APPOINTMENT, THE AGENT ASSUMES THE FIDUCIARY AND OTHER LEGAL RESPONSIBILITIES OF AN AGENT.

_____
(Typed or Printed Name of Agent)

_____
(Signature of Agent)

WITNESS:

Signature: _____

Printed Name: _____ Date: _____

Address: _____

Signature: _____

Printed Name: _____ Date: _____

Address: _____