

HEALTH CARE POWER OF ATTORNEY

A. KNOW ALL PERSONS BY THESE PRESENTS, that I, _____, parent and natural guardian of _____, a minor ("child"), Social Security Number _____, do hereby appoint _____ to serve as true and lawful agent ("Agent") for me and on my behalf and in my name to make health care decisions for child as Agent may deem advisable in his absolute discretion, including, without limitation, any of the following:

1. Medical Procedures. To arrange and authorize, withhold or withdraw authorization for medication, medical care and therapeutic and surgical procedures on child's behalf; and to arrange and authorize, withhold or withdraw authorization for food, and/or water medically supplied by tube or otherwise.

2. Access to Records. To have all access to child's medical and hospital records and all information regarding child's physical and mental health.

3. Relief from Pain. To consent to and arrange for the administration of pain-relieving drugs of any type, or surgical or medical procedures designed to relieve child's pain even though their use may lead to permanent physical damage, addiction or hasten the moment of, but not intentionally cause, death.

4. General. To take all legal action and do all other things which my Agent may deem proper in order to carry out any of the foregoing enumerated powers, which shall be construed in the broadest possible manner. The descriptive headings of this Limited Health Care Power of Attorney shall not be deemed to affect the meaning or construction of any of the provisions hereof or to limit in any way the construction thereof in the broadest possible manner.

B. I hereby ratify and confirm all that my said Agent shall do or cause to be done by virtue of these presents. I specifically direct that my Agents shall not be subject to any liability by reason of Agent's decisions, acts or failures to act, all of which shall be conclusive and binding upon me, my estate and my heirs.

C. This Limited Health Care Power of Attorney shall not be effective unless no parent or legal or natural guardian is available to make rational decisions concerning child.

D. A photocopy of this fully executed Limited Health Care Power of Attorney shall be deemed to be an original and anyone to whom such photocopy is presented is authorized to act with respect thereto as if such photocopy were an original.

I CERTIFY THAT I HAVE READ THE PROVISIONS OF THIS LIMITED HEALTH CARE POWER OF ATTORNEY, THAT SUCH PROVISIONS HAVE BEEN EXPLAINED TO ME TO MY SATISFACTION, THAT I UNDERSTAND THE FULL IMPORT OF SUCH PROVISIONS AND THAT THEY STATE MY WISHES AND DESIRES. I FURTHER CERTIFY THAT I AM COMPETENT TO EXECUTE THIS DOCUMENT.

IN WITNESS WHEREOF, and intending to be legally bound, I have hereunto set my hand and seal this _____ day of _____, 2003.

_____(L.S.)
Principal

Witness:

Witness:

Print Name:
Address:

Print Name:
Address

STATE OF _____ :
COUNTY OF _____ : SS

On this _____ day of _____, 2003, before me, a notary public, personally appeared _____, known to me (or satisfactorily proved) to be the Principal named in the foregoing Limited Health Care Power of Attorney, and acknowledged that he/she executed the same for the purposes therein contained.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal.

(Notary Seal)

Notary Public
My Commission Expires: