Limited Power of Attorney – Medical Treatment

KNOW ALL MEN BY THESE PRESENCE THAT, _____,
(parent/legal guardian name(s))

of _____, _____, do, and each of us does hereby, appoint
(city) (state)

_____, our attorney for the sole and limited
(care giver name(s))

person of authorizing medical care and treatment for our child/children

_____.
(child/children name(s))

We hereby grant and give to our said attorney full authority and power to do and perform any an all acts necessary or incidental to the performance and execution of the powers herein expressly granted, with power to do and perform all acts authorized hereby as fully to all intent and purpose as we might or could do if personally present.

This limited Power of Attorney shall expire and terminate _____ days
(number)
from the date hereof. Any person relying on this Power of Attorney may rely on a photocopy as if it were an original.

_____
(Signature of Parent or Legal Guardian)

STATE OF _____

COUNTY OF _____

Subscribed and sworn to before me this _____ day of _____, _____.
(date) (month) (year)

_____
Notary Public Signature

My Commission Expires:

Notary Stamp:

_____
(date)