Safe Families *for* Children

POWER OF ATTORNEY
FOR HEALTH CARE OF A MINOR DEPENDENT

Name of Minor Child: _____

Child's Date of Birth: _____

Name of Parent(s)/Legal Guardian(s): _____

Name of Health Care Agent(s) (Safe Family): _____

Date of Appointment: _____

Date of Termination (if applicable): _____

I/we, the biological parent(s)/legal guardian(s) of the above-named child (the "Child"), hereby appoint the health care agent(s) designated above (collectively or individually the "Health Care Agent"), as my/our attorney-in-fact and agent to act on my/our behalf in any way I/we could act in person, and grant to the Health Care Agent the power and authority to make any and all decisions for me/us concerning the Child's personal care and medical, dental and mental health treatment, including but not limited to routine and ordinary care, evaluation, treatment, diagnostic evaluations of any sort, invasive and non-invasive procedures to the extent customarily used (of an emergency or non-emergency nature), in-patient or out-patient hospitalization, and all other health care, and to require, withhold, or withdraw any type of medical treatment or procedure as I/we may want to require, withhold or withdraw for the Child if I/we could act in person. The Health Care Agent shall have the same access to medical records as I/we have, including the right to disclose the contents to others.

Biological Parent/Legal Guardian: _____ *(Initial)* Biological Parent/Legal Guardian: _____ *(Initial)*

Without limiting the generality of the foregoing appointment, I/we specifically authorize the Health Care Agent to assume the following medical care rights and responsibilities:

A. Physical Examination

I/we authorize the Health Care Agent to consent to, and obtain a physical examination for, the Child.

B. Routine and Ordinary Medical Care

I/we authorize the Health Care Agent to consent to and obtain any routine or ordinary medical care for the Child, including inoculations and immunizations. I/we also understand that the Health Care Agent

will make a reasonable effort to contact me/us prior to such care but that failure to contact me/us will not be a reason to not obtain care for the Child.

C. Diagnosis and Treatment

I/we authorize the Health Care Agent to consent to and to obtain diagnosis and treatment for the Child, whether invasive or non-invasive, and as deemed necessary and appropriate to prevent our care for any medical condition the Child is reasonably believed to have or to alleviate the Child's pain and suffering.

D. Extraordinary Medical Care

I/we authorize the Health Care Agent to consent to and obtain any extraordinary medical care for the Child including hospitalization, blood transfusion, surgery, and treatment in the event of a medical emergency which, in the opinion of the attending physician or healthcare provider, may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed. I/we also understand that the Health Care Agent will make a reasonable effort to contact me/us prior to such care, but that failure to contact me/us will not be a reason to deny treatment to the Child.

E. Medical Card or Private Medical Insurance

If the Child has a Medicaid card, I/we agree to give the Health Care Agent the current card and will continue to provide the current card throughout the Child's stay. If the Child has private medical insurance, I/we will give the Health Care Agent a copy of my/our insurance card and other pertinent information regarding such insurance and to pay any co-payments or other charges not covered by such insurance. If the Child is not covered under and insurance plan either private or public, I/we will agree to pay for any and all medical care that is required for the Child. I/we agree to pay all co-pays, deductible or other expenses not covered and/or reimbursed by insurance.

Applicable card numbers and providers: _____

Biological Parent/Legal Guardian: _____ *(Initial)*

Biological Parent/Legal Guardian: _____ *(Initial)*

I/we direct the Health Care Agent to take such action on behalf of the Child as is reasonably necessary to alleviate suffering and to authorize any treatment as to which the potential and expected benefits outweigh the potential and expected burdens.

Biological Parent/Legal Guardian: _____ *(Initial)*

Biological Parent/Legal Guardian: _____ *(Initial)*

If more than one person is named as the Health Care Agent by this instrument and any such person named as the Health Care Agent shall die, become incompetent, resign, refuse to accept the office of Health Care Agent or become unavailable for any reason, I name the remaining person or persons who are

designated above as the successor Health Care Agent to act in such capacity; if at any time there are no such named person(s) to act as the Health Care Agent, then I name Twin Cedars Youth and Family Services, Inc. (TCYFS), to act through any of its officers or through any employee of its "Safe Families for Children-West Georgia" program, as the sole successor Health Care Agent. Any successor Health Care Agent shall have all of the same powers and immunities as the originally named Health Care Agent.

I/we certify that the Child is not emancipated.

I/WE UNDERSTAND THIS IS A LEGAL DOCUMENT. I/WE AM/ARE FULLY INFORMED AS TO THE CONTENTS OF THIS DOCUMENT AND AM/ARE SIGNING THIS FORM VOLUNTARILY.

Notice: All parents/legal guardians must sign below and initial above as noted.

Signed _____ / _____
(Biological Parent/Legal Guardian) *(Date)*

Signed _____ / _____
(Biological Parent/Legal Guardian) *(Date)*

WITNESS this the _____ day of _____, _____.
(Date) *(Month)* *(Year)*

_____
Witness

_____
(Printed Signature)

[NOTARY SEAL]

NOTARY:

Signed and sealed in the presence of:

_____
Notary Public

Copy of document provided to Biological Parent(s) Legal Guardian(s) and Safe Family Parents(s), with original placed in TCYFS/Safe Family Parent file.