

MEDICAL POWER OF ATTORNEY

I, _____, do give
(Name of Parent or Guardian)
permission for the following people to make decisions regarding medical treatment for
my child, _____, should the need arise.
(Child's Name)

Power of Attorney is given for emergency medical and dental care, including anesthesia when it is needed. This consent is effective from this date and remains active until the date indicated here, unless otherwise revoked:

(Date)

Name: _____

Address: _____

Phone: _____

Beeper: _____

Name: _____

Address: _____

Phone: _____

Beeper: _____

Name: _____

Address: _____

Phone: _____

Beeper: _____

NOTARY

Parent name: _____

Parent signature: _____

Date

Notary name: _____

Notary signature: _____

Date

seal here