

**DURABLE SPECIAL POWER OF ATTORNEY
FOR MEDICAL SERVICES**

This Special Power of Attorney applies to the following minor child(ren) or incapacitated adult:

PATIENT'S FULL NAME: _____

PLACE OF RESIDENCE: _____

DATE OF BIRTH: _____

The undersigned, as parent(s) or legal guardian(s) of the minor child(ren) or incapacitated adult, named above, hereby constitute(s) and appoint(s) the following named adult as Attorney-in-Fact in the place of the undersigned in the manner, and to the extent, described hereafter.

Adult who is authorized to act as Attorney-in-Fact for the undersigned:

ADULT'S FULL NAME: _____

PLACE OF RESIDENCE: _____

DATE OF BIRTH: _____

The Attorney-in-Fact named above shall have full power to consent to and authorize any medical, surgical or dental care, or any hospitalization, which he/she deems necessary or advisable for the health or treatment of any illness or injury of the minor child(ren) or incapacitated adult, named above. This Power of Attorney shall not be affected by the disability or incompetence of the Principal.

If the minor child(ren) or incapacitated, named above has/have any special medical problems, including allergies, they are:

PATIENT'S FULL NAME: _____

DESCRIPTION OF MEDICAL PROBLEM: _____

LIST OF ALLERGIES: _____

LIST OF MEDICATIONS: _____

Date

Signature of Parent or Legal Guardian:

STATE OF)

County of)

This Special Power of Attorney was personally acknowledged before me on _____ by _____, who is either known to me or proved his or her identity to me.

Signature of Notary Public

Notary Seal