MEDICAL POWER OF ATTORNEY
DESIGNATION OF HEALTH CARE AGENT
FOR
CHILD'S NAME HERE

THE STATE OF TEXAS §
§ **KNOW ALL MEN BY THESE PRESENTS**
COUNTY OF _____ §

I, _____, the mother/father of CHILD'S NAME HERE, being of sound mind, willfully and voluntarily appoint my _____, AGENT NAME HERE, of ADDRESS OF APPOINTED PERSON HERE, _____ County, Texas ZIPCODE HERE, as my agent to make any and all health care decisions for my minor son/daughter, CHILD'S NAME HERE, who was born on ___ _____DATE OF BIRTH HERE, except to the extent that I state otherwise in this document. This medical power of attorney takes effect immediately (or put a specific date here or use language such as "when I am detained or deported") and is given to make provision for the care and treatment of my son/daughter, CHILD'S NAME HERE, in the event that I am out of town, am unable to be located or reached, or am unable to make health care decisions for him/her.

In the event AGENT'S NAME HERE shall predecease me or become unable to serve for any reason as my son's/daughter's health care agent, I appoint my _____, ALTERNATE AGENT NAME HERE of ADDRESS HERE, _____ County, Texas ZIPCODE HERE, as my successor agent and all the powers, duties and responsibilities granted and imposed upon AGENT NAME HERE shall devolve upon and be executed by ALTERNATE AGENT HERE.

LIMITATIONS ON THE DECISION MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

None.

The original of this document is kept with NAME HERE at ADDRESS HERE.

The following individuals or institutions have signed copies (one or more):

Name:
Address:

Home Phone:
Work Phone:

DURATION.

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke this power of attorney. If I am out of town

or unable to be reached or unable to make health care decisions for my son/daughter, CHILD'S NAME HERE, when this power of attorney expires, the authority I have granted my agent continues until the time I return to town, become available or become able to make health care decisions for my son/daughter, CHILD'S NAME HERE.

The authority I have granted my agent shall include, but not be limited to the following:

1. To request, review, and receive any and all medical, hospital and related information and records, and to execute a release or other document required to obtain such information;

2. To consent to the disclosure of medical and related information to others;

3. To employ and discharge medical and related personnel;

4. To consent, refuse consent, or withdraw consent to medical care, treatment, service or procedure, subject to my directions expressed in an effective Directive to Physicians;

5. To provide appropriate relief from pain;

6. To arrange for care and lodging in a hospital or other medical facility;

7. To grant releases to health care professionals or institutions to assure that my wishes for my son's/daughter's care are fulfilled;

8. To authorize anatomical gifts; and

9. To arrange to hire and to pay the salaries of employees, nurses and similar health care providers, and to see that required tax returns are filed.

This power of attorney ends on the following date: WHEN REVOKED BY ME or A SPECIFIC DATE.

PRIOR DESIGNATIONS REVOKED.

I revoke any prior medical power of attorney for my son/daughter, CHILD'S NAME HERE.

ACKNOWLEDGMENT OF DISCLOSURE STATEMENT.

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

I sign my name to this medical power of attorney for my son/daughter, CHILD'S NAME HERE on DATE HERE at _____, _____ County, Texas.

PARENT NAME HERE, Mother/Father of CHILD'S NAME HERE
ADDRESS HERE

STATEMENT AND SIGNATURE OF FIRST WITNESS.

I am not the person appointed as agent by this document. I am not related to either PARENT'S NAME HERE or her/his son/daughter, CHILD'S NAME HERE, by blood or marriage. I would not be entitled to any portion of the estate of PARENT'S NAME HERE or CHILD'S NAME HERE, on the death of CHILD'S NAME HERE. I am not the attending physician of PARENT'S NAME HERE or CHILD'S NAME HERE or an employee of the attending physician. I have no claim against any portion of the estate of PARENT'S NEMA HERE or CHILD'S NAME HERE, on the death of CHILD'S NAME HERE. Furthermore, if I am an employee of a health care facility in which CHILD'S NAME HERE is a patient, I am not involved in providing direct patient care to CHILD'S NAME HERE and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

WITNESS NAME HERE
WITNESS ADDRESS HERE
DATE

STATEMENT AND SIGNATURE OF SECOND WITNESS.

I am not the person appointed as agent by this document. I am not related to either PARENT'S NAME HERE or her/his son/daughter, CHILD'S NAME HERE, by blood or marriage. I would not be entitled to any portion of the estate of PARENT'S NAME HERE or CHILD'S NAME HERE, on the death of CHILD'S NAME HERE. I am not the attending physician of PARENT'S NAME HERE or CHILD'S NAME HERE or an employee of the attending physician. I have no claim against any portion of the estate of PARENT'S NEMA HERE or CHILD'S NAME HERE, on the death of CHILD'S NAME HERE. Furthermore, if I am an employee of a health care facility in which CHILD'S NAME HERE is a patient, I am not involved in providing direct patient care to CHILD'S NAME HERE and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

WITNESS NAME HERE
WITNESS ADDRESS HERE
DATE

SUBSCRIBED AND SWORN TO BEFORE ME by the said PARENT'S NAME HERE, Principal, and by the said and, Witnesses, DATE HERE.

_____

Notary Public, State of Texas

INFORMATION CONCERNING THE MEDICAL POWER OF ATTORNEY

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for your son, CHILD'S NAME HERE, in accordance with your wishes when you are out of town or unavailable or no longer capable of making them for your son/daughter, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because "health care" means any treatment, service or procedure to maintain, diagnose or treat your son's/daughter's physical or mental condition, your agent has the power to make a broad range of health care decisions for your son/daughter. Your agent may consent, refuse to consent or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery or abortion. A physician must comply with your agent's instructions or allow your son/daughter to be transferred to another physician.

Your agent's authority begins immediately so that proper care and treatment can be provided for your son/daughter in the event you are unavailable, are out of town or lack the competence to make health care decisions for him/her.

Your agent is obligated to follow your instructions when making decisions on your son's/daughter's behalf. Unless you state otherwise, your agent has the same authority to make decisions about your son's/daughter's health care as you would have had if you had been personally present.

It is important that you discuss this document with your son's/daughter's physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If your son/daughter does not have a physician, you should talk with your physician or if you do not have a physician, with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent for your son/daughter should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your son's/daughter's health or residential care provider (e.g., his physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or as your son's/daughter's health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your son's/daughter's health care agent. You should discuss this document with your agent and your

son's/daughter's physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your son's/daughter's behalf.

Even after you have signed this document, you have the right to make health care decisions for your son/daughter as long as you are available, not out of town and are able to do so and treatment cannot be given to your son/daughter or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your son's/daughter's health or residential care provider orally or in writing, or by your execution of a subsequent medical power of attorney for your son/daughter. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for your son/daughter.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS:

(1) YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC; OR

(2) YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.

THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

(1) the person you have designated as your agent;

(2) a person related to you by blood or marriage;

(3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;

(4) your attending physician;

(5) an employee of your attending physician;

(6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or

(7) a person who, at the time this power of attorney is executed, has a claim against

any part of your estate after your death.

I certify I have received a copy of this "Information Concerning the Medical Power of Attorney."

_____

PARENT'S NAME HERE
DATE