HEALTH CARE POWER OF ATTORNEY

I, _____, parent or legal guardian of the minor child identified below, residing at _____, hereby appoint _____ as my true and lawful attorney-in-fact , to act in my name, place and stead and to do any of the acts listed below with respect to the care and custody of the minor child, _____ (name), _____ (DOB) and _____(Social Security Number) (the "child"). The attorney-in-fact shall serve as the child's health care agent, make health care decisions as authorized in this Power of Attorney and set forth below.

The attorney-in-fact is authorized to make health care decisions on behalf of the child, including but not limited to, decisions regarding the child's medical care and treatment, including the power to consent to medically necessary surgery and general anesthesia services for the child ordered by or under the authorization of a licensed health care practitioner. The attorney-in-fact is authorized to discuss the child's healthcare with health care personnel who may be treating the child, to examine the child's health care records, and to consent to the disclosure of the child's records, as he/she deems appropriate.

The attorney-in-fact is authorized to sign health care and insurance forms as necessary to carry out these decisions; to file any claims for health care insurance, to obtain information from any insurance company or program with respect to any health care insurance that is in effect for the child, to apply for health care benefits on behalf of the child, and to arrange for the continuance and maintenance of such health care insurance; provided however, that the attorney-in-fact shall not be required to execute any documents which would involve incurring any personal liability for any care, treatment, or insurance premiums, deductibles and copayments.

I affirm that I will be financially responsible for payment of all charges that are not paid by any insurer for any medical and treatment the child receives and for any insurance premiums associated with continuance or maintenance of health care insurance.

I hereby give and grant unto the attorney-in-fact full power and authority to do and perform each and every act and matter concerning the subject of this Power of Attorney as fully and effectually for all intents and purposes as I could do legally if I were present. The attorney-in-fact and the attorney-in-fact's estate, heirs, successors and assigns, acting in good faith, are hereby released and forever discharged from any and all liability and from all claims or demands of all kinds whatsoever by me or my estate, heirs, successors, and assigns arising out of the acts or omissions of the attorney-in-fact, except for willful misconduct on part of the attorney-in-fact.

No third party relying on this Power of Attorney will be liable for any losses, damages, or claims caused by compliance with the action requested by the attorney-in-fact, unless that third party has actual knowledge of my death or the revocation of this Power of Attorney.

.IN WITNESS WHEREOF, I have hereunto set my hand and seal this ____day or _____ 20_____.
This Power of Attorney shall become effective when I sign and execute it below. Unless sooner revoked or terminated by me, this Power of Attorney shall **become null and void on the ___ day of _____, 20___. (MUST FILL IN EXPIRATION DATE)**

WITNESS PARENT/LEGAL GUARDIAN

_____ _____

_____ _____

Print Name Print Name

STATE OF FLORIDA }COUNTY OF _____ }

SWORN TO AND SUNSCRIBED before me this ____ day of _____, 20____ by

_____ _____

[SEAL] Notary Public of State of Florida

_____

Printed/Typed/Stamped Name of Notary Public

☐ Personally known [or]

☐ Produced _____ as identification