

Medical Power of Attorney Form Designation of Health Care Agent

I, PARENT/GUARDIAN _____ [insert parent/guardian name here] am the parent or guardian of the following CHILD _____ [insert child name here] and appoint the following HOST PARENTS _____ [enter names of host parent or parents here] who reside at the following address:

Address: _____ City: _____, Texas,
Zip _____, Phone _____ as my CHILD's agent to make any and all health care decisions for my CHILD, except to the extent I state otherwise in this document. This Medical Power of Attorney takes effect on the date noted below. There are no limitations to this authority.

The original of this document is kept at Poetry Community Christian School, 18688 FM 986, Poetry, TX 75160 where my CHILD attends school, with a copy to the HOST PARENTS.

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 the power of attorney. This power of attorney ends on the following date: _____.

Acknowledgment of Disclosure Statement

I have read and understand that information contained in the disclosure statement (see reverse side)

Date signed: _____ day of _____, 20____.

(Signature) PARENT/GUARDIAN of CHILD noted above.

Statement of Witness

I am not the person appointed an agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal 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 Signature: _____ Witness printed/typed name: _____

Witness Address: _____

Date: _____, 20____.

Medical Power of Attorney Disclosure Statement Form

This is an important legal document. Before signing this document, you should know these important facts:

Unless you state otherwise, this document gives the person you name as your agent the authority to make all health care decisions for you in accordance with your wishes, when your doctor certifies that you lack the capacity to make health care decisions. Because "health care" means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. 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 you to be transferred to another physician.

Your agent's authority begins when your doctor certifies that you lack the competence to make health care decisions. Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to ensure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone 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's advice.

The person you appoint as agent should be someone you know and trust; is 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 health or residential care provider (e.g., your 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 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 health care agent. You should discuss this document with your agent and your physician; give each a signed copy; and indicate on the document the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf. Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so. In such case, treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing, or by your execution of a subsequent medical power of attorney. 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 you.

This Power of Attorney is not valid unless it is signed in the presence of two or more competent adult witnesses.

The following persons may not act as one of the witnesses:

The person you have designated as your agent; a person related to you by blood or marriage, 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; your attending physician; an employee of your attending physician; 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 a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.

Information is provided courtesy of the Texas Medical Association for general information and is not intended to serve as legal advice. Any legal advice needed for a particular situation should be obtained from an attorney. Permission is granted to reproduce this document.

- See more at: <http://www.texmed.org/Template.aspx?id=65#FORM>