POWER OF ATTORNEY FOR THE
MEDICAL CARE AND EDUCATION OF A CHILD

DESIGNATION OF HEALTH CARE AGENT

I, FIELD(P), a resident of FIELD(County) County, Texas, as of this date and by this document, do nominate, constitute, and appoint **FIELD(FIELD(MedicalPOA1))**, of FIELD(AddressFIELD(MedicalPOA1)), FIELD(CityStateZipFIELD(MedicalPOA1)), telephone FIELD(PhoneFIELD(MedicalPOA1))IFNOTBLANK(FIELD(EMailFIELD(MedicalPOA1))), e-mail FIELD(EMailFIELD(MedicalPOA1))ENDIF , as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney for health care takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

Part I: To be filled out and/or initialed by parent(s).

Minor Child's Name_____

Mother/Legal Guardian's Name & Address

_____

_____

_____

Father/Legal Guardian's Name & Address

_____

_____

_____

Caregiver's Name & Address

_____

_____

_____

(check one of the following)

(____) Both parents are living and have signed this document;

(____) One parent is deceased;

(____) The parent-child relationship has been terminated for one of the parents;

(____) The decision-making authority of one parent has been limited by a court order;

(____) One parent is the sole managing conservator of the minor child and has sent a copy of this document, by certified mail, return receipt requested, to the other parent at that parent's last known address; or

(____) The other parent has not consented to the appointment or consent cannot be obtained because _____.

Temporary care-giving authority regarding the minor child will be given to the caregiver during the period of the following type(s) of hardship (check at least one):

(____) the serious illness or incarceration of a parent or legal guardian;

(____) the physical or mental condition of the parent or legal guardian or the child is such that care and supervision of the child cannot be provided;

(____) the need for medical or mental health treatment (including substance abuse treatment) by the parent or legal guardian;

(____) the military deployment of the parent or legal guardian; or

(____) other (please describe) _____, at a time when the other parent or legal guardian, if applicable, is unable to care for the child.

(____) I/We the undersigned, authorize the named caregiver to do one or more of the following (check as appropriate):

(_____) enroll the child in school and extracurricular activities;

(_____) obtain medical, dental, and mental health treatment for the child; and

(_____) provide for the child's food, lodging, housing, recreation, and travel.

(____) I/We grant the following additional powers to the named care-giver:_____.

(____) I/We understand that this document does not provide legal custody to the caregiver. If at any time I/we disagree with a decision of the named caregiver or choose to make any health care or

educational decisions for my/our child, I/we must revoke the power of attorney, in writing, and provide written documentation to the health care provider and the local education agency (i.e., school).

(____) I/We understand that this document may be terminated by another written document signed by either parent with legal authority or by any order of a court with competent jurisdiction.

Part II: To be initialed by caregiver as applicable.

(____) I understand that this document, properly executed, gives me the right to enroll the minor child in the local education agency serving the area where I reside.

(____) I understand that this document does not provide me with legal custody of the minor child.

(____) I understand that, prior to enrollment, the local education agency may require documentation of the minor child's residence with a caregiver and/or documentation or other verification of the validity of the stated hardship.

(____) I understand that, except to the extent limited by federal law, I shall be assigned the rights, duties, and responsibilities that would otherwise be assigned to the parent, legal guardian, or legal custodian of the minor child.

(____) I understand that if the minor child ceases to reside with me, I am required by law to notify any person, school, or health care provider to whom I have given this document.

I/We declare under penalty of perjury under the laws of the State of Texas that the foregoing is true and correct.

Signed this ___ day of _____, 20__.

_____

Mother/Legal Guardian

The Mother/Legal Guardian, _____, personally appeared before me this _____ day of _____, 20__.

_____

Notary Public in and for the State of Texas

My commission expires: _____

Signed this ___ day of _____, 20__.

_____

Father/Legal Guardian

The Father/Legal Guardian, _____, personally appeared before me this _____ day of _____, 20__.

_____

Notary Public in and for the State of Texas

My commission expires: _____

Signed this ___ day of _____, 20__.

_____

Caregiver

The Caregiver, _____, personally appeared before me this _____ day of _____, 20__.

_____

Notary Public in and for the State of Texas

My commission expires: _____

NOTICE TO THE LOCAL EDUCATION AGENCY AND/OR HEALTH CARE PROVIDER: No person, school official, or health care provider who acts in good faith reliance on a power of attorney for care of a minor child to enroll the child in school or to provide medical, dental, or mental health care, without actual knowledge of facts contrary to those authorized, is subject to criminal or civil liability to any person, or is subject to professional disciplinary action for such reliance. This immunity applies even if medical, dental, or mental health care is provided to a minor child or the child is enrolled in a school in contravention of the wishes of the child's parent, if the person, school official, or health care provider has been provided a copy of an appropriately executed power of attorney for care of the minor child and has not been provided written documentation that the parent has revoked the power of attorney for care of the minor child. Nothing in this document relieves any individual from liability for a violation of any other law.

LIMITATIONS ON THE DECISION MAKING AUTHORITY OF MY AGENT

The limitations on the decision making authority of my agent are as follows:

_____

_____

DESIGNATION OF ALTERNATE AGENT

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:IFNOTBLANK(MedicalPOA2)

1. First Alternate Agent: **FIELD(FIELD(MedicalPOA2))**, of FIELD(AddressFIELD(MedicalPOA2)), FIELD(CityStateZipFIELD(MedicalPOA2)), telephone FIELD(PhoneFIELD(MedicalPOA2))IFNOTBLANK(FIELD(EMailFIELD(MedicalPOA2))), e-mail FIELD(EMail FIELD(MedicalPOA2))ENDIF .ENDIF IFNOTBLANK(MedicalPOA3)

2. Second Alternate Agent: **FIELD(FIELD(MedicalPOA3))**, of FIELD(AddressFIELD(MedicalPOA3)), FIELD(CityStateZipFIELD(MedicalPOA3)), telephone FIELD(PhoneFIELD(MedicalPOA3))IFNOTBLANK(FIELD(EMailFIELD(MedicalPOA3))), e-mail FIELD(EMail FIELD(MedicalPOA3))ENDIF .ENDIF IFNOTBLANK(MedicalPOA4)

3. Third Alternate Agent: **FIELD(FIELD(MedicalPOA4))**, of FIELD(AddressFIELD(MedicalPOA4)), FIELD(CityStateZipFIELD(MedicalPOA4)), telephone FIELD(PhoneFIELD(MedicalPOA4)) IFNOTBLANK(FIELD(EMailFIELD(MedicalPOA4))), e-mail FIELD(EMailFIELD(MedicalPOA4))ENDIF .ENDIF

The original of this document is kept at FIELD(AddressP), FIELD(CityStateZipP). The following individuals or institutions have electronic copies of the signed instrument: Michael A. Koenecke, Attorney, P.O. Box 830190, Richardson, Texas 75083-0190, (972) 387-2904.

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. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

This power of attorney ends on the following date: EXISTS INDEFINITELY.

PRIOR DESIGNATIONS REVOKED

I revoke any prior medical durable power of attorney.

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.

IF(VARIABLE(vOneStep))ELSE EMBEDMACRO(MergeFileType (Form!) PowerBarShow (On!))ENDIF I sign my name to this medical durable power of attorney on this the IF(VARIABLE(vOneStep))VARIABLE(vDay)VARIABLE(vOrdinal) day of VARIABLE(vMonth), VARIABLE(vYear)ELSE MRGCMND(VARIABLE(vDay)VARIABLE(vOrdinal) day of VARIABLE(vMonth), VARIABLE(vYear))ENDIF , at IF(VARIABLE(vOneStep))VARIABLE(vCounty) ELSE MRGCMND(VARIABLE(vCounty))ENDIF County, Texas.

_____

FIELD(P)

STATE OF TEXAS §
§
COUNTY OF IF(VARIABLE(vOneStep))TOUPPER(VARIABLE(vCounty))ELSE MRGCMND(TOUPPER(VARIABLE(vCounty)))ENDIF §

BEFORE ME, THE UNDERSIGNED AUTHORITY, on this day personally appeared FIELD(P), who stated that IF("TOUPPER(SUBSTR(FIELD(Sex);1;1))"="M")heELSE sheENDIF signed the above document for the purposes and considerations therein expressed.

SIGNED on this the VARIABLE(vDay)VARIABLE(vOrdinal) day of VARIABLE(vMonth), VARIABLE(vYear).

_____

Notary Public, State of Texas