ILLINOIS POWER OF ATTORNEY
FOR HEALTH CARE OF A MINOR DEPENDENT
PURSUANT TO 755 ILCS 45/4-1 et seq.

1. My child is _____ born on _____.

I, _____, being the biological parent or Legal guardian, hereby appoint _____, as my attorney-in-fact (my "agent" to act for me and in my name in any way I could act in person) to make any and all decisions concerning the child's personal care, medical treatment; including but not limited to routine and ordinary care, evaluation, treatment, including diagnostic evaluations of any sort, including invasive and non-invasive procedures to the extent customarily used (of an emergency or non-emergency nature), including in-patient or out-patient hospitalization and all other health care and to require, withhold or withdraw any type of medical treatment or procedure as I would want to require, withhold or withdraw for my child if I could act in person. My agent shall have the same access to medical records that I have, including the right to disclose the contents to others.

I specifically acknowledge and authorize my appointed agent to assume the following medical care rights and responsibilities:

A. Physical Examination

I authorize my appointed agent to consent to and obtain physical examination for my child.

B. Routine and Ordinary Medical Care

I authorize my appointed agent to consent to and obtain any routine or ordinary medical care for my child including inoculations and immunizations.

C. Diagnosis and Treatment

I authorize my appointed agent to consent to and to obtain diagnosis and treatment for my child, whether invasive or non-invasive, as deemed necessary and appropriate to prevent or care for any medical condition my child is reasonably believed to have or alleviate my child's pain and suffering.

D. Extraordinary Medical Care

I authorize my appointed agent to consent to and obtain any extraordinary medical care for my child including hospitalization, blood transfusion, surgery, and treatment in the event of a medical emergency which, in the opinion of the attending physician, may endanger my child's life, cause disfigurement, physical impairment or undue discomfort if delayed.

2. I direct my appointed agent to take such action on behalf of my child as a reasonably necessary to alleviate suffering and to authorize any treatment as to which the potential and expected benefits outweigh the potential and expected burdens.

3. This power of attorney shall become upon execution and shall terminate on the child's eighteenth birthday.

4. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my appointed agent.

Signed _____ / _____
(Biological Parent/Legal Guardian) (Date)

Signed _____ / _____
(Additional Biological Parent/Legal Guardian) (Date)

Witnessed _____ / _____
(Date)