Family Health Care

TEMPORARY DELEGATION OF POWER BY PARENT/GUARDIAN & LIMITED POWER OF ATTORNEY FOR CONSENT TO MEDICAL TREATMENT OF CHILD/LEGALLY INCAPACITATED PERSON

Parents/Guardians: Don't leave your loved ones unprotected. Give your permission to a responsible adult so that Family Health Care staff can treat your loved ones in the event of an unexpected nonemergent situation if you are going to be temporarily separated from your child or another person for whom you are responsible (parent, grandparent, etc.). Except in emergent situations, Family Health Care personnel cannot provide unexpected nonemergent treatment for your child or legally incapacitated person in the event he or she becomes ill or injured without authorization. Your loved one's care could be needlessly delayed while our staff attempts to contact you. With the proper consent, you assure your loved ones of immediate care should it be necessary. Fill out this limited power of attorney form and leave it with whomever will be responsible for your loved one in your absence. You are encouraged to follow the same procedure whenever you will be away from your loved one.

Name of child or legally incapacitated person: ______________________________

Address: ______________________________

Date of Birth: ______________________ Last Tetanus Immunization: ______________

Known Allergies/Drug Sensitivities/Medical Condition: ______________________________

____

Insurance/Health Benefits and Physician Information:

Insurance Company Name or Health Benefit Program: ______________________________
Group No.: ______________________ Subscriber I.D.: ______________________
Physician Name and Phone ______________________________

I/we are the parent(s) or legal guardian(s) of the above named child or legally incapacitated person. We consent to this Limited Power of Attorney for the individual named below to act for me/us and to give the required authorization for the delivery of medical/dental care, diagnosis and treatment, including necessary surgery, on behalf of my/our minor child/legally incapacitated person named above and to do all other necessary related acts for treatment during my absence from ______________ to ____________. I/we understand this delegation includes permission to receive health information about the child/legally incapacitated person necessary to make health care decisions. This Limited Power of Attorney is given pursuant to the provisions of MCL 700.5103.

Limitations to this Delegation (if any): ______________________________

IN NO EVENT IS THIS LIMITED POWER OF ATTORNEY EFFECTIVE FOR MORE THAN SIX (6) MONTHS FROM THE SIGNATURE DATE BELOW. THIS FORM DOES NOT DELEGATE POWER TO CONSENT TO MARRIAGE OR ADOPTION.

I/We appoint the following individual(s):

Name: ______________________ Address: ______________________ Phone: ______________

Name: ______________________ Address: ______________________ Phone: ______________

X ______________________________ X ______________________________
Parent or Guardian (*check box*) **Parent or Guardian (*check box*)**

The signature(s) above should be witnessed by a person (not an employee/contractor of Family Health Care).

Witness: X ______________________________ Date: ______________________

Name: ______________________ Address: ______________________ Phone: ______________