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

1. My/our child is _____ born on _____.

I/we, _____ (Biological Parent/Legal Guardian), hereby appoint _____ as my/our 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 for me/us concerning my/our 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/we would want to require, withhold or withdraw for my/our child if I could act in person. My/our agent shall have the same access to medical records that I have, including the right to disclose the contents to others.

Biological Parent/Legal Guardian: *_____ ; Additional Biological Parent/Legal Guardian: *_____
(Initial) *(Initial)*

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

A. Physical Examination

I/we authorize my/our appointed agent to consent to and obtain a physical examination for my/our child.

B. Routine and Ordinary Medical Care

I/we authorize my/our appointed agent to consent to and obtain any routine or ordinary medical care for my child including inoculations and immunizations. I /we also understand that staff will make a reasonable effort to contact me/us prior to such care but that failure to contact me/us will not be a reason to not obtain care for my/our child.

C. Diagnosis and Treatment

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

D. Extraordinary Medical Care

I/we authorize my/our appointed agent to consent to and obtain any extraordinary medical care for my/our 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 his/her life, cause disfigurement, physical impairment or undue discomfort if delayed. I/we also understand that staff will make a reasonable effort to contact me/us prior to such care, but that failure to contact me/us will not be a reason to deny treatment to my/our child.

E. Medical Card or Private Medical Insurance

If my/our child has a Medicaid card, I /we agree to give my/our appointed agent the current card and will continue to provide the current card throughout the child's stay. If my/our child has private medical insurance, I /we will give my/our appointed agent a copy of my/our insurance card and other pertinent information regarding the medical insurance and to pay any co-payments or other charges not covered by the medical insurance. If my/our child is not covered under an insurance plan either private or public, I/we agree to pay for any and all medical care that it required for my/our child.

Applicable card numbers and providers: _____

_____

I/we agree to pay uncovered charges: *_____ / _____
(*Biological Parent/Legal Guardian)* *(Date*)

2. I/we 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.

Biological Parent/Legal Guardian: *_____ ; Additional Biological Parent/Legal Guardian: *_____
(Initial) *(Initial)*

3. I/we want my child's life to be prolonged and I /we want life-sustaining treatment to be provided to my child unless the child is in a coma which the child's attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when my/our child has suffered irreversible coma, I/we want life-sustaining treatment to be withheld or discontinued.

Biological Parent/Legal Guardian: *_____ ; Additional Biological Parent/Legal Guardian: *_____
(Initial) *(Initial)*

4. This power of attorney shall become effective on _____(*Date*).

5. This power of attorney shall terminate on _____.
(*Date*)

6. I/we nominate as my/our agent _____.

7. If any agent named by me/us shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I/we name the following as successors to such agent:

_____

8. If a guardian of my person is to be appointed, I/we nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.

9. I/we am/are fully informed as to all the contents of this form and understand the full import of this grant of powers to my/our appointed agent.

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

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

Witnessed _____ / _____
(Date)

****

Required documentation to be completed by:

***Biological Parent(s) / Legal Guardian:** ***#1** *(initials);*
***#1-E** *(signature/date);*
***#2** *(initials);*
***#3** *(initials);*
***#9** *(signature/date).*

- ***Appointed Agent indicated:*** ***#1** *(x2);* ***#6***

☐ *Copy of document provided to Biological Parent(s)/Legal Guardian(s) and Appointed Agent(s); with original placed into _____ (location in which the primary document will be stored).*