DURABLE POWER OF ATTORNEY FOR HEALTH CARE RELATED DECISIONS

GENERAL STATEMENT OF AUTHORITY GRANTED

I, _____________, the undersigned principal, hereby appoint the _________________to act on my behalf, and to be my minor children's (_____________, **DOB** _______, **and**_____________, **DOB** _________) agent for health care and education related decisions and pursuant to the language stated below, on my behalf to:

HEALTH CARE DECISIONS

1. Consent, refuse consent, or withdraw consent, concerning my minor children ____________________, to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition, and to make decisions about organ donation, autopsy and disposition of the body;

2. Make all necessary arrangements at any hospital, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institution; to employ or discharge health care personnel to include physicians, psychiatrists, psychologists, dentists, nurses, therapists or any other person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care as the agent shall deem necessary for the physical, mental and emotional well being of my minor children,_______________; and

3. Request, receive and review any information, verbal or written, regarding my minor children, ___________________________personal affairs or physical or mental health including medical and hospital records and to execute any releases of other documents that may be required in order to obtain such information.

LIMITATIONS OF AUTHORITY

The powers of the agent herein shall be limited to the extent set out in writing in this durable power of attorney for health care and education related decisions, and shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the natural death act.

EFFECTIVE TIME

This power of attorney for health care and education related decisions shall

become effective immediately and shall not be affected by my subsequent disability. The rights, powers, and authority granted herein shall remain in full force and effect thereafter until my death. This power of attorney shall not be affected by any subsequent disability or incapacity.

REVOCATION

Any durable power of attorney for health care and education related decisions I have previously made is hereby revoked.

Any party presented with a copy of this Durable Power of Attorney for Health Care may rely upon such presentation as conclusive evidence of its present validity and effectiveness. No person who acts in reliance upon the representations of or the authority granted my agent shall incur any liability to me or to my estate as a result of permitting my agent to exercise any power.

Dated this _____ day of ______________ 20 __

____
XXXX

ACKNOWLEDGMENT TO
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE RELATED DECISIONS
OF ______________________________

STATE OF KANSAS)
) **SS:**
COUNTY OF SEDGWICK)

Before me, the undersigned authority, on this day personally appeared ______________________known to me to be the person executing this Durable Power of Attorney, whose name is subscribed to the foregoing instrument; and, she being by me first duly sworn, said ____________________ declared to me in my presence that said instrument, Durable Power of Attorney for Health Care Related Decisions, is for her minor children________________________________, and she has willingly made and executed it as her free and voluntary act and deed for the purposes therein expressed; and that said Principal, at that time possessed the rights of majority, was of sound mind and under no restraint.

Subscribed and sworn to before me by____________________, this ______ day of ______________ 20___.

____
NOTARY PUBLIC

My appointment expires:

____