POWER OF ATTORNEY DELEGATING PARENTAL POWER FOR HEALTH CARE

Authorized by S. 48.979, Wis. Stats

- This form must be signed by all parents who have legal custody of the children named below.
- This form allows parents to delegate their ability to consent to certain health care for their children to another person, who is referred to in this form as an "agent."
- Only parents who have legal custody may use this form.
- Parents may not use this form for a child who is subject to the jurisdiction of juvenile court.
- This Power of Attorney does not deny custodial or noncustodial parents any of their rights regarding the health care of the children, whether granted by court order or law.
- This form may not be used to give the power to consent to the performance or inducement of an abortion.
- You are not required to give permission to the agent to consent to all health care when using this form. Instead, you may limit the agent's ability to consent to specific kinds of care.

THIS POWER OF ATTORNEY IS TO PROVIDE FOR THE HEALTH CARE OF:

	Child 1	Child 2	Child 3*
Name:			
Address:			
Date of Birth:			

*(*If more than three children, please complete an additional form.)*

EFFECTIVE DATE AND TERM OF THIS DELEGATION

This Power of Attorney takes effect on ___ /___ /___ and will remain in effect until ___ /___ /___.

- If no termination date is given, this Power of Attorney will remain in effect for a period of one (1) year after the effective date. Further, if the agent is not a relative of the child, this Power of Attorney will terminate one (1) year from the effective date.
- This Power of Attorney may be revoked or cancelled in writing at any time by a parent who has legal custody of the children. Any such revocation will cancel the delegation of parental powers made by this Power of Attorney, except with respect to acts already taken in reliance on this Power of Attorney.

PRIMARY CARE ASSOCIATES of Appleton, LTD

DELEGATION OF POWER

I give permission to the agent to consent to the following health care for the children named above:

☐ **ALL** Health Care

OR ONLY ⟶ (*if you did not mark "ALL Health Care," please mark all that apply below*)

☐ Ordinary or routine health care

☐ Immunizations/Vaccinations

☐ Dental care

☐ Emergency procedures and blood transfusions

☐ Other:_____

Would you like the agent to be able to view the health information of the children named above? (*This permission would allow the agent to make more informed health care decisions for the children.*)

☐ YES ☐ NO

SIGNATURES OF PARENTS

(IF MORE THAN ONE PARENT HAS LEGAL CUSTODY OF THE CHILDREN, BOTH PARENTS MUST SIGN THIS POWER OF ATTORNEY FORM.)

I have legal custody of the children named above. If only one parent is signing below, I represent that there is no other parent with legal custody of the children named above. I give permission to the agent named below to consent to the children's health care.

	Parent 1	Parent 2
Parent's Signature:		
Date of Signature:		
Parent's Printed Name:		
Parent's Address:		
Parent's Phone Number:		
Parent's Email Address:		

DESIGNATED AGENT

Agent's Name	Agent's Telephone Number(s)
Agent's Email Address	Relationship of Agent to the Child(ren)
Agent's Home Address	

STATEMENT OF AGENT

- I understand that the parents named above have delegated to me the powers specified in this Power of Attorney regarding the health care of the children named above.
- I further understand that this Power of Attorney may be revoked in writing at any time by a parent who has legal custody of the children named above.
- I hereby declare that I have read this Power of Attorney, understand the powers delegated to me by this Power of Attorney, am willing and able to undertake those powers, and accept those powers.

Agent's Signature	Date