BAYCARE CLINIC

POWER OF ATTORNEY DELEGATING PARENTAL POWER

AUTHORIZED BY S. 48.979, Wis. Stats.

In order to provide medical treatment to your minor child in your absence, we need this form to be completed.

1. NAME(S) OF CHILD(REN)

This power of attorney is for the purpose of providing for the care of:

_____

(Name, address, and date of birth of child)

_____

(Name, address, and date of birth of child)

_____

(Name, address, and date of birth of child)

2. **DELEGATION OF POWER TO DESIGNATED AGENT** (*person accompanying my children*)

I,_____, _____,
(name of parent) (address)

state that I have legal custody of the child(ren) named above[1].

I delegate my parental power to the below identified Agent. The parental power I am delegating is as follows:

_____ The power to consent to disclosure of health information about the child(ren)[2]
_____ The power to consent to all health care; or
_____ The power to consent to only the following health care:
- _____ Ordinary or routine health care, excluding major surgical procedures, extraordinary procedures and experimental treatment
- _____ Dental care

3. EFFECTIVE DATE AND TERM OF THIS DELEGATION

This Power of Attorney takes effect on_____and will remain in effect until_____ but shall not exceed one year. This Power of Attorney may be revoked in writing at any time by a parent who has legal custody of the child(ren) and such a revocation invalidates 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.

In accordance with Wisconsin Statute 48.028(5)(a) completion of this form alone is insufficient for delegation of the care of an Indian child, as defined under ICWA.

_____ By initialing here, I confirm that none of the children named above are considered an Indian child.

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[1] Only a parent who has legal custody may use this form. A parent may not use this form to delegate parental powers regarding a child who is subject to the jurisdiction of the juvenile court under s. 48.13, 48.14, 938.12, 938.13, or 938.14, Wis. Stats.

[2] This form alone does not authorize the release of records. A separate Authorization for Release of Records is required in order to release records.

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4. SIGNATURE(S) OF PARENT(S)

I hereby declare that I have read this Power of Attorney regarding the care of my minor children listed above. I understand the powers I am delegating to the Agent listed below. I hereby agree to defend, indemnify and hold harmless the providers, BayCare Clinic and other persons who act in reliance upon the representations made in this Power of Attorney.

First parent name:_____ Date: _____

Signature of parent: _____

Parent's address: _____.

Parent's telephone number: _____Parent's e-mail address_____

Second parent name:_____ Date: _____

Signature of parent: _____

Parent's address: _____

Parent's telephone number: _____Parent's e-mail address_____

5. **STATEMENT OF DESIGNATED AGENT** (*person accompanying my children*)

_____ _____
(name of agent) (address)

understand that _____ delegated to me the powers specified in this
(name(s) of parents(s)

Power of Attorney regarding the care of _____.
(children(s) name(s)

I hereby declare that I have read this Power of Attorney, understand the powers delegated to me by this Power of Attorney, am fit, willing, and able to undertake those powers, and accept those powers.

Agent's signature: _____ Date: _____

Agent's printed name: _____ Relationship of agent to child(ren): _____

Agent's address: _____

Agent's telephone number(s): _____ Agent's e-mail address: _____

6. INSURANCE INFORMATION (Minor)

Insurance Company: _____ Policy Number: _____

Policy Holder: _____ Effective Date of Coverage: _____

Employer: _____ Group Number: _____

Policy Holder's Date of Birth: _____