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,_______________________, state that I have legal custody of the child(ren) named above[1]
(name and address of parent.)

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

[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.

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.

Signature of parent____________________**Date ___________**
Parent's name printed__________________________________
Parent's address ______________________________________
Parent's telephone number _____________________________
Parent's e-mail address ________________________________

Signature of parent____________________Date ____________
Parent's name printed__________________________________
Parent's address ______________________________________
Parent's telephone number _____________________________
Parent's e-mail address ________________________________

5. STATEMENT OF DESIGNATED AGENT (*person accompanying my children*)
I,____(name and address of agent), understand that
____(name(s) of parent(s)) delegated to me the powers specified in this Power of Attorney regarding the care of________________________________.
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 __________

Name of agent ____
Agent's address ____
Agent's telephone number(s) ___________________________________
Agent's e-mail address _______________________________________
Relationship of agent to child(ren) ________________________________

6. INSURANCE INFORMATION

Insurance Company: ____
Policy Number: ____
Policy Holder: ____
Effective Date of Coverage: _______________________________________
Employer:____
Group Number: ____
Policy Holder's Date of Birth: _____________________________________