

POWER OF ATTORNEY FOR HEALTH CARE FOR MY CHILD

The purpose of this power of attorney is to give the adult leaders of Boy Scout Troop 567 broad powers to make health care decisions for my son in the event of an illness or injury.

My son, _____, is a member of Boy Scout Troop 567, Wildwood, Missouri. Boy Scout Troop 567 conducts many activities, including hiking, climbing, repelling, canoeing, swimming, other water activities, and camping, in which my son will participate. I understand that my son may become ill or injured while participating in an activity with Boy Scout Troop 567, in which, in the opinion of an adult leader, my son may need medical attention or assistance. Examples of cases where my son may need medical attention or assistance include a strain, sprain, cut, bruise, scrape, bump, fracture, skin rash (such as impetigo, poison oak or ivy), bites (such as bee stings, snake bites, or other animal bites), allergic reactions, foreign substances in the eye or skin, upset stomach, diarrhea, pink eye, burn, concussion, fever, etc.

POWER OF ATTORNEY made the ____ day of _____, 20__.

1. APPOINTMENT OF AGENT

I, _____,
(insert name, address, and telephone number of parent)

hereby designate and appoint the adult leaders of Boy Scout Troop 567 as my attorneys in fact (my agents) to act for me and in my name (in any way I could act in person) to make any and all decisions for my son, _____, concerning his personal care, medical treatment, or medical procedure. My agent shall have the right to consent to all types of medical treatments or medical procedures. My agent shall have the right to admit my son to a doctor=s office, out patient medical facility, urgent care facility, hospital, or other institution or facility.

I shall be financially responsible for all medical costs. Attached is a copy of the health insurance card for my son.

2. WHEN THE AGENT=S AUTHORITY TERMINATES

This power of attorney shall terminate on December 31, 2010.

3. THIS POWER OF ATTORNEY WAS VOLUNTARILY EXECUTED

I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agents.

Signed _____

Dated _____

NOTARY PUBLIC

State of Missouri)
) SS
St. Louis County)

The undersigned, a notary public in and for the above county and state, certifies that _____, known to me to be the same person whose name is subscribed as the parent in the foregoing Power of Attorney for Health Care For My Child, having appeared before me and having been first duly sworn, then declared to me that he/she signed and executed the instrument, and that he/she willingly signed, and that he/she executed it was his/her free and voluntary act for the purposes therein expressed.

Dated: _____

Notary Public

My commission expires: _____

Please attach a copy of you insurance card to this document.