

**ILLINOIS POWER OF ATTORNEY
FOR HEALTH CARE OF A MINOR DEPENDENT
PURSUANT TO 755 ILCS 45/4-1 et seq.**

1. My/our child is _____ born on _____.

I/we (*Biological Parent/Legal Guardian*), * _____, hereby appoint (*Safe Family Parent(s)*) _____, as my attorney-in-fact (my “agent” to act for me and in my name in any way I could act in person) to make any and all decisions for me/us concerning my/our child’s personal care, medical treatment; including but not limited to routine and ordinary care, evaluation, treatment, including diagnostic evaluations of any sort, including invasive and non-invasive procedures to the extent customarily used (of an emergency or non-emergency nature), including in-patient or out-patient hospitalization and all other health care and to require, withhold or withdraw any type of medical treatment or procedure as I/we would want to require, withhold or withdraw for my/our child if I could act in person. My/our agent shall have the same access to medical records that I have, including the right to disclose the contents to others.

Biological Parent/Legal Guardian: * _____ ; Additional Biological Parent/Legal Guardian: * _____
(Initial) (Initial)

I/we specifically acknowledge and authorize my/our appointed agent _____ (*Safe Family Parent(s)*) to assume the following medical care rights and responsibilities:

A. Physical Examination

I/we authorize my/our appointed agent (*Safe Family Parent(s)*) to consent to and obtain a physical examination for my/our child.

B. Routine and Ordinary Medical Care

I/we authorize my/our appointed agent (*Safe Family Parent(s)*) to consent to and obtain any routine or ordinary medical care for my child including inoculations and immunizations. I /we also understand that staff will make a reasonable effort to contact me/us prior to such care but that failure to contact me/us will not be a reason to not obtain care for my/our child.

C. Diagnosis and Treatment

I/we authorize my/our appointed (*Safe Family Parent(s)*) to consent to and to obtain diagnosis and treatment for my/our child, whether invasive or non-invasive, as is deemed necessary and appropriate to prevent or care for any medical condition my child is reasonably believed to have or to alleviate my/our child’s pain and suffering.

D. Extraordinary Medical Care

I/we authorize my/our appointed (*Safe Family Parent(s)*) to consent to and obtain any extraordinary medical care for my/our child including hospitalization, blood transfusion, surgery, and treatment in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed. I/we also understand that staff will make a reasonable effort to contact me/us prior to such care, but that failure to contact me/us will not be a reason to deny treatment to my/our child.

E. Medical Card or Private Medical Insurance

If my/our child has a Medicaid card, I/we agree to give my/our appointed (*Safe Family Parent(s)*) the current card and will continue to provide the current card throughout the child's stay. If my/our child has private medical insurance, I/we will give my/our appointed (*Safe Family Parent(s)*) a copy of my/our insurance card and other pertinent information regarding the medical insurance and to pay any co-payments or other charges not covered by the medical insurance. If my/our child is not covered under an insurance plan either private or public, I/we agree to pay for any and all medical care that it required for my/our child.

Applicable card numbers and providers: _____

I/we agree to pay uncovered charges: * _____ / _____
(*Biological Parent/Legal Guardian*) (Date)

2. I/we direct my appointed agent (*Safe Family Parent*) to take such action on behalf of my child as a reasonably necessary to alleviate suffering and to authorize any treatment as to which the potential and expected benefits outweigh the potential and expected burdens.

Biological Parent/Legal Guardian: * _____ ; Additional Biological Parent/Legal Guardian: * _____
(Initial) (Initial)

3. I/we want my child's life to be prolonged and I/we want life-sustaining treatment to be provided to my child unless the child is in a coma which the child's attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when my/our child has suffered irreversible coma, I/we want life-sustaining treatment to be withheld or discontinued.

Biological Parent/Legal Guardian: * _____ ; Additional Biological Parent/Legal Guardian: * _____
(Initial) (Initial)

4. This power of attorney shall become effective on _____.

(Date)

5. This power of attorney shall terminate on _____.
(Date)

6. I/we nominate as my/our agent (Safe Family Parent(s)) _____.

7. If any agent named by me/us shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I/we name the following as successors to such agent: LYDIA Home Association.

8. If a guardian of my person is to be appointed, I/we nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.

9. I/we am/are fully informed as to all the contents of this form and understand the full import of this grant of powers to my/our appointed agent (Safe Family Parent(s)).

Signed * _____ / _____
(Biological Parent/Legal Guardian) (Date)

Signed * _____ / _____
(Additional Biological Parent/Legal Guardian) (Date)

Witnessed _____ / _____
(Date)

Required documentation to be completed by:

- *Biological Parent(s) / Legal Guardian:** #1 (initials);
#1-E (signature/date);
#2 (initials);
#3 (initials);
#9 (signature/date).

- **Safe Family Parent(s indicated):** #1 (x2); #6

Copy of document provided to Biological Parent/Legal Guardian and Safe Family Parent(s); with original placed into LYDIA/Safe Family Parent file.