

# Durable Special Power of Attorney for Care of Minor Child

I do hereby appoint Jim D. Hinkle, Stacy B. Hinkle, Randall C. Frederick, Jenna A. King, Danielle C. Lair and/or any other adult designated by any of them, to serve as my attorneys-in-fact (my "Agents"), giving to them the power to make decisions with regard to health care for my child,  
\_\_\_\_\_ (Child's DOB: \_\_\_/\_\_\_/\_\_\_).

My Agents are associated with the Youth Ministry of the Sycamore View Church of Christ, and this authorization is for the purpose of permitting medical treatment when my child is participating in Youth Ministry activities/programs, and I am not present or available to make such health care decisions. This authorization shall be effective until my child reaches age eighteen (18), unless I shall revoke it in writing prior thereto.

## Section 1. Powers of Agents

Any one of my Agents may make decisions regarding medical attention, services, and care for my child. These shall include, but shall not be limited to:

Choice of physician and choice of hospital or minor emergency clinic.

The unrestricted power to determine, upon advice of a physician, whether my child is in need of surgery or medication.

The absolute and sole discretion to authorize or withhold such surgery or medication.

Any decision concerning other care, comfort, maintenance, and support as my Agent may determine, including the power to exercise any written consents or approvals which may at any time be required with respect to any such medical decisions regarding my child's physical or mental condition.

## Section 2. Immunity for Reliance upon Representations of Agents

No person who acts in reliance on the representations of my Agents or the authority granted under this Durable Special Power of Attorney for Health Care shall incur any liability to us, my heirs, or assigns as a result of permitting any of my Agents to exercise any power granted under.

## Section 3. Disability

This Durable Special Power of Attorney for Health Care shall not be affected if I become disabled or incapacitated.

## Section 4. Immunity of Agents

I do hereby release and hold harmless my Agents from any and all liability any decision made pursuant to this authorization. I further state that I am of lawful age and legally competent to execute this authorization, that I understand that the terms herein are contractual and are not a mere recital, and that I have executed this authorization and waiver as my own free act and deed.

I do hereby certify that I am the parent/legal guardian having sole legal custody of the minor child. The consent of the minor child's other parent/legal guardian cannot be obtained due to \_\_\_\_\_.

Signature of Parent/Legal Guardian: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

STATE OF TENNESSEE  
COUNTY OF SHELBY

Before me, a Notary Public in and for the State and County aforesaid, personally appeared \_\_\_\_\_ (Mother), with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

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Child's Social Security Number: \_\_\_\_\_

Child's Birthdate: \_\_\_\_\_

Insurance Provider and Policy Number: \_\_\_\_\_

List of allergies, including medication allergies: \_\_\_\_\_

Emergency Contacts (Name & Phone): \_\_\_\_\_

\_\_\_\_\_