

**NON-DURABLE POWER OF ATTORNEY FOR PHYSICAL  
AND HEALTH CARE OF MINOR CHILD**

**THE POWERS YOU GRANT BELOW WILL TERMINATE IF YOU BECOME  
DISABLED OR INCOMPETENT**

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE EXPLAINED IN THE UNIFORM STATUTORY FORM POWER OF ATTORNEY ACT. IF YOU HAVE ANY QUESTIONS ABOUT THESE POWERS, OBTAIN COMPETENT LEGAL ADVICE. YOU MAY REVOKE THIS POWER OF ATTORNEY IF YOU LATER WISH TO DO SO.

POWER OF ATTORNEY made this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

I, \_\_\_\_\_, residing  
at \_\_\_\_\_,  
as the sole custodial parent of \_\_\_\_\_ [Child Name]  
hereby appoint: \_\_\_\_\_

\_\_\_\_\_  
*(insert the name and address of the person appointed)*

as my attorney-in-fact (my "agent") to act for and in my name (in any way I could act in person) to provide for the temporary care of my child and to make any and all decisions for me concerning my child, \_\_\_\_\_ (child's name) in regards to his personal care, medical treatment, hospitalization and health care to require, withhold or withdraw any type of medical treatment or procedure, even though my child's death may ensue. My agent shall make every effort to prolong to the greatest extent possible, the chances of my child to recover without regard to my child's condition or the costs of procedures until such time as I can be contacted and provide directions regarding life-support, food and hydration.

My agent shall have the same access to my child's medical records that I have, including the right to disclose the contents to others.

The powers granted above shall not include the following powers or shall be subject to the following rules or limitations:

- My agent shall not have the power or authority to authorize the termination of life-support, food or hydration.

This power of attorney shall become effective on the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_. While this power of attorney is in effect, I will be \_\_\_\_\_,  
\_\_\_\_\_, and can be located by \_\_\_\_\_.

This power of attorney shall terminate as soon as I resume the physical care of my child or as soon as I direct medical care personnel or other authorities of the termination of this power of attorney.

If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I name the following (each to act alone and successively, in the order named) as successors to such agent,

Minnehaha Academy  
3100 West River Parkway  
Minneapolis, MN 55406

\_\_\_\_\_ [First Successor] and  
\_\_\_\_\_ [Second Successor].

For the purposes of this paragraph, a person shall be considered incompetent if and while the person is a minor or an adjudicated incompetent or disabled person or the person is unable to give prompt and intelligent consideration to health care matters, as certified by a licensed physician.

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

Signed this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
(Your Signature)

#### CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

This document was acknowledged before me on \_\_\_\_\_ [Date] by  
\_\_\_\_\_ [name of principal].

[Notary Seal, if any]:

\_\_\_\_\_  
(Signature of Notarial Officer)

Notary Public for the State of

\_\_\_\_\_  
My commission expires:

\_\_\_\_\_

#### ACKNOWLEDGMENT OF AGENT

BY ACCEPTING OR ACTING UNDER THE APPOINTMENT, THE AGENT ASSUMES THE FIDUCIARY AND OTHER LEGAL RESPONSIBILITIES OF AN AGENT.

\_\_\_\_\_  
(Typed or Printed Name of Agent)

\_\_\_\_\_  
(Signature of Agent)

**WITNESS:**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

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