

SPECIAL MEDICAL POWER OF ATTORNEY

I, _____, do hereby authorize

_____ of _____
(Address)

_____, to execute and consent to any and all medical and hospital care and treatment, including any major surgery deemed necessary by a duly licensed physician selected by my Attorney-In-Fact for the health and well-being of my following named children:

NAME	BIRTH DATE	AGE

Signature

Address

City/State/Zip

Telephone

Subscribed and sworn to before me this
_____ day of _____, 2_____.

Notary Public

My commission expires: _____