Must be Notarized **Form E**

LIMITED POWER OF ATTORNEY FOR HEALTH CARE

That I, _____, a resident of _____ County, _____, as parent and/or legal guardian of _____ (hereinafter "my minor child"), do hereby make, constitute and appoint _____and _____of _____County, Kentucky, as my true
(youth minister)
true and lawful attorney in fact (hereinafter "my attorney"), for myself and my minor child and in my name, place and stead, in my attorney's sole discretion, to make any and all health care decisions relating to my minor child while in the custody of my attorney. I give permission to my attorney to make decisions relating to any necessary medical treatment including but not limited to hospitalization, surgery, administration of medications, anesthesia or injections, for my minor child while in the custody of my attorney.

This instrument is intended to, and does hereby, grant to my attorney full power and authority to do and perform each and every act and thing whatsoever requisite, necessary, and proper to be done, in the exercise of any of the rights and powers herein granted as fully, to all intents and purposes, as I might or could do if personally present, and I hereby ratify and confirm all that my attorney shall do or cause to be done by virtue thereof.

I, on behalf of myself, my minor child and our heirs, assigns, executors and personal representatives, release, hold harmless and discharge forever my attorney, and his/her heirs, assigns, executors and personal representatives for any and all liability, claims, losses, damages, costs or expenses and waive any such claims arising directly or indirectly from health care decisions made by my attorney pursuant to this power of attorney.

I, on behalf of myself and my minor child, agree to be financially responsible for any and all health care treatment arising in connection with any illness or injury of my minor child and the costs thereof and I agree to compensate my attorney for any such costs.

The rights, powers and authority of my attorney shall commence on Nov. 21, 2019 and shall remain in full force and effect through Nov.23, 2019 unless this power of attorney is revoked prior to that time.

IN TESTIMONY WHEREOF, witness my signature:

Printed name: _____
Signature: _____
Date: _____

STATE OF KENTUCKY
COUNTY OF KENTON

Subscribed, sworn to and acknowledged before me this _____ day of _____, 20__.

My Commission Expires: _____Notary Public _____