MEDICAL POWER OF ATTORNEY
DESIGNATION OF HEALTH CARE AGENT

I, _____, of Victoria County, Texas, appoint:

NAME: _____

ADDRESS:_____

PHONE:_____

as my agent to make any and all health care decisions for my child _____ for a period of _____ to _____, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I am unable to make health care decisions for my child.

The original of this document is kept at: _____

_____.

The following individuals or institutions have signed copies:

NAME: _____

ADDRESS: _____

DURATION.

I understand that this Power Of Attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the Power Of Attorney. If I am unable to make health care decisions for my child when this Power Of Attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for my child.

PRIOR DESIGNATIONS REVOKED.

I revoke any prior durable power of attorney for health care for my child.

_____