POWER OF ATTORNEY

DELEGATING AUTHORITY TO MAKE HEALTHCARE DECISIONS

Name of **Child or Incapacitated Person**: ______________________________

Date of Birth: ______________________________

Name of **Parent or Legal Guardian**: ______________________________

Address: ______________________________

Phone Number: ______________________________

Name of Individual Authorized
to Make Healthcare Decisions: ______________________________
(Relationship to Child or Incapacitated Person)

Date of Birth: ______________________________

Address: ______________________________

Phone Number: ______________________________

KNOW ALL PERSONS BY THESE PRESENTS:

That I, ________________________________, **a parent or a legal guardian** of the above named child or incapacitated person, in accordance with Idaho Code § 15-5-104, do hereby appoint ____ as my lawful agent/attorney-in-fact, to seek and consent to any healthcare, treatment, or services that are recommended by a licensed healthcare provider to whom the above named child or incapacitated person is presented; to receive healthcare information pertaining to the above named child or incapacitated person; and to otherwise make healthcare decisions for the child or incapacitated person named above, subject to the following limitations or restrictions:

- ☐ No limitations or restrictions
- ☐ Other ____

Any person, including my agent/attorney-in-fact, may rely upon the validity of this power of attorney or a copy of it, unless that person actually knows that it is terminated or invalid. I hereby release and agree to defend, indemnify, and hold harmless my agent/attorney-in-fact and any licensed healthcare provider who relies on this power of attorney when providing care or treatment to the above named child or incapacitated person from any losses, liabilities, claims, judgments, and damages.

IF DELEGATING FOR A MINOR, TO A CERTAIN “CLOSE” RELATIVE AS DESCRIBED BELOW:

If my agent/attorney-in-fact is [ ] **a grandparent of the above named child**, [ ] **an adult sibling of either parent of the above named child**, or [ ] **an adult sibling of the above named child**, this power of attorney shall remain in full force and effect for a period of **three (3) years**, OR [ ] from ___________ until ____________________, unless earlier revoked by me in writing.

IF DELEGATING FOR AN INCAPACITATED PERSON, OR A MINOR, TO A PERSON WHO IS NOT A “CLOSE” RELATIVE:

If my agent/attorney is not a person listed immediately above (not a “close” relative of the above named child), this power of attorney shall remain in full force and effect from ________________________ until ______________________ (**not to exceed six (6) months**), unless earlier revoked by me in writing.

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Signature of Parent or Legal Guardian Date