LIMITED POWER OF ATTORNEY

I, _____, during the period of

_____, 20____ through _____, 20____,

(not to exceed one year) do hereby appoint _____

my attorney(s)-in-fact to act in my absence and after a diligent effort to locate me, in my name, place and stead in any way which I myself could do, if I were personally present, with respect to health care decisions concerning my son/daughter/custodial minor,

_____.

(Child's full name)

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this document may act here under, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation or termination shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this document.

IN WITNESS WHEREOF I have hereunto signed my name,_____,
this _____ day of _____, 20____.

STATE OF NEW YORK)

County of Cattaraugus) (L.S.)

ss:

On this _____day of _____, 20____, before me personally appeared to me known and known to me to be the person described in and who executed the foregoing power of attorney and he duly acknowledged to me that he executed the same.

_____

(Notary Public)

CHILD'S NAME: _____ DATE OF BIRTH: _____

If your child becomes injured and needs emergency treatment, it will be necessary for you , as parent or legal guardian, to give consent for treatment.

The purpose of the attached form is to give another person or agency the authority to grant such permission (consent) in your absence. This will allow the physician or emergency care facility to begin treatment for your child without delay.

The following information will also help to expedite the care:

PAST HEALTH PROBLEMS: _____

_____

_____

_____

ALLERGIES:_____

_____

_____

CURRENT MEDICATIONS:_____

_____

_____

DATE OF LAST TETANUS IMMUNIZATION:_____

PEDIATRICIAN:_____

PARENT/LEGAL GUARDIAN INFORMATION

NAME:_____

ADDRESS:_____

CITY & STATE:_____ZIP CODE:_____

HOME PHONE:_____CELL PHONE:_____

WORK PHONE:_____

INSURANCE INFORMATION: _____

_____