AUTHORIZATION OF HEALTH CARE CONSENT FOR MINOR

I, _____ , of _____ (County), _____ am the custodial parent having legal custody of _____ (Child's Name), a minor child, age _____, born _____ (Month/Day/Year).

I authorize _____, _____ or _____ adults in whose care the minor child has been entrusted, and who resides at _____(Address), _____(Address), _____(Address), to do any acts which may be necessary or proper to provide for the health care of the minor child, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including administration of anesthesia, X-ray examinations, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

This consent shall be effective from the date of execution to, and including, _____ (M/D/Y).

By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as the contents of this document and understand the full import of this grant of powers to the agent named herein.

Custodial Parent _____ Date _____

STATE OF NORTH CAROLINA

COUNTY OF _____

On this _____ day of _____, personally appeared before me the named _____, to me known and known to me to be the person described in and who executed the foregoing instrument and he (or she) acknowledges that he (or she) executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

Notary Public

My Commission Expires: