By executing this Power of Attorney for Health Care, I authorize

_____ to act as my agent in consenting to medical treatment for

my minor child, _____. This authorization will

remain in effect for one year in accordance with Missouri Revised Statute 475.024 or

until revoked by me in writing, whichever occurs first.

_____ _____

Name Printed Relationship to Patient

_____ _____

Signature Date

Notarization Required:

STATE OF MISSOURI)

SS

COUNTY OF _____)

On this ____ day of _____(month), _____ (year), before me personally appeared _____, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of _____, State of Missouri, the day and year first above written.

_____

Notary Public

My Commission Expires: _____