

THIS FORM IS NOT INTENDED AND IS NOT A SUBSTITUTE FOR LEGAL ADVICE AND SHOULD ONLY BE A STARTING POINT FOR YOU. AN ATTORNEY SHOULD BE CONSULTED FOR ALL SERIOUS LEGAL MATTERS. THIS FORM MAY HAVE TO BE MODIFIED TO SUIT YOUR PARTICULAR NEEDS.

**POWER OF ATTORNEY: INCLUDING CARE AND CUSTODY OF CHILD, CHILDREN, AND WARD**

*This document authorizes another person (called your "Agent" or "Attorney in Fact") to make medical and other health care decisions for your child(ren) and/or ward(s) if you become incapacitated, as described below. It does not authorize anyone to make medical and other health-care decisions for you. You may revoke this power of attorney if you later wish to do so.*

*The powers granted by this document are broad and sweeping. They are explained in the Durable Power of Attorney Act, Chapter XII, Texas Probate Code, and Chapter 32, Texas Family Code. If you have any questions about these powers, obtain competent legal advice.*

**DELEGATION OF POWER**

I, \_\_\_\_\_ at  
complete address: \_\_\_\_\_

\_\_\_\_\_,  
office, home, and cell phone numbers: \_\_\_\_\_,

\_\_\_\_\_,  
email address, if any: \_\_\_\_\_,

appoint \_\_\_\_\_ at  
complete address: \_\_\_\_\_

\_\_\_\_\_,  
office, home, and cell phone numbers: \_\_\_\_\_,

\_\_\_\_\_,  
email address, if any: \_\_\_\_\_,

as my agent to act for me in any lawful way with respect to all of the following powers except for a power I have crossed out below.

*TO WITHHOLD A POWER, YOU MUST CROSS OUT EACH POWER IN THE LIST BELOW THAT YOU WANT TO WITHHOLD.*

- Real property transactions;
- Tangible personal property transactions;
- Stock and bond transactions;
- Commodity and option transactions;
- Banking and other financial institution transactions;
- Business operating transactions;
- Insurance and annuity transactions;
- Estate, trust, and other beneficiary transactions;
- Claims and litigation;
- Personal and family maintenance;

Benefits from social security, Medicare, Medicaid, or other governmental programs or civil or military service;  
Retirement plan transactions;  
Tax matters.

IF NO POWER LISTED ABOVE IS CROSSED OUT, THIS DOCUMENT SHALL BE CONSTRUED AND INTERPRETED AS A GENERAL POWER OF ATTORNEY AND MY AGENT SHALL HAVE THE POWER AND AUTHORITY TO PERFORM OR UNDERTAKE ANY ACTION I COULD PERFORM OR UNDERTAKE IF I WERE PERSONALLY PRESENT.

**SPECIAL INSTRUCTIONS:**

**CHILDREN**

On the following lines I give the following special instructions outlining the powers granted to my agent regarding the care and custody of my child(ren) and/or ward(s):

I, \_\_\_\_\_,  
parent(s) of the child(ren) identified below, residing at

\_\_\_\_\_ hereby appoint \_\_\_\_\_  
*(if more than one attorney-in-fact is appointed, add "Jointly," "either of them" or "any one of them" to indicate how they must act), at complete address: \_\_\_\_\_*

\_\_\_\_\_ office, home, and cell phone numbers: \_\_\_\_\_

\_\_\_\_\_ email address, if any: \_\_\_\_\_

as my Attorney(s)-in-Fact, to act in my name, place and stead and do or execute all or any of the acts, deeds and things listed in (a) – (e) below which I have initialed, with respect to the care and custody of the following child(ren)/ward(s):

Full Legal Name and Nickname	Birth Date	Social Security Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Initials: *Initial those you want to apply. Cross out those that you do not want to apply.*

\_\_\_\_\_ (a) To participate in decisions regarding the child(ren)'s education including attending conferences with the child(ren)'s teachers or any other educational authorities, granting permission for the child(ren)'s participation in school trips and other activities, and making any other decisions and executing any documents related to their education.

\_\_\_\_\_ (b) To grant permission and consent to the child(ren) participating in any activity sponsored by any group, association or organization which activity the Attorney(s)-in-Fact may deem appropriate.

Initials: *(Check all that apply. Cross out those that do not apply)*

\_\_\_\_\_ (c) To make health care decisions on behalf of the child(ren), including making decisions, whether routine or emergency in nature, regarding the child(ren)'s:

- \_\_\_\_\_ physical medical care and treatment;
- \_\_\_\_\_ dental care and treatment;
- \_\_\_\_\_ mental health care and treatment;
- \_\_\_\_\_ substance abuse care and treatment;
- \_\_\_\_\_ immunizations; and
- \_\_\_\_\_ admissions to hospitals or other institutions.

These health care decisions may include, but not be limited to, the ability to consent to, to refuse to consent to, or to withdraw consent to the provision of any care, tests, treatment, surgery, service or procedure to maintain, diagnose or treat a physical or mental condition, as well as the right to sign such health care and insurance forms as may be necessary to carry out such decisions; to talk with health care personnel who may be treating the child(ren) and to examine the child(ren)'s health care records and to consent to the disclosure of such records in circumstances the Attorney(s)-in-Fact may deem appropriate; to file claims for health care insurance, to obtain information from any insurance company or program with respect to any health care insurance that is in effect for the child(ren), and to arrange for the continuance and maintenance of such health care insurance; provided however, that the Attorney(s)-in-Fact shall not be required to execute any documents which would involve incurring any personal liability for any such care, treatment, or insurance premiums, deductibles, and copayments, and I affirm that I will be responsible for payment for any such care or treatment consented to by the Attorney(s)-in-Fact which is not covered by insurance and for any insurance premiums associated with continuance or maintenance of such health care insurance.

\_\_\_\_\_ (d) To generally do and perform all matters and things, to execute all other instruments of every kind which may be necessary or proper to effectuate all powers granted in this document, or any other matter or thing appertaining to my child(ren)/ward, with the same full powers and validity as I could if personally present.

\_\_\_\_\_ (e) SPECIFICALLY EXCLUDED FROM THE AUTHORITY AND POWERS GRANTED HEREIN IS THE AUTHORITY OR POWER TO CONSENT TO: *(list any exclusions)* \_\_\_\_\_

\_\_\_\_\_.

GIFTS

Special instructions applicable to gifts (*initial in front of the following sentence to have it apply*):

\_\_\_\_\_ I grant my agent the power to apply my property to make gifts, except that the amount of a gift to an individual may not exceed the amount of annual exclusions allowed from the federal gift tax for the calendar year of the gift.

*UNLESS YOU DIRECT OTHERWISE BELOW, THIS POWER OF ATTORNEY IS EFFECTIVE IMMEDIATELY AND WILL CONTINUE UNTIL IT IS REVOKED.*

*YOU MAY CHOOSE ONLY ONE OF THE FOLLOWING THREE ALTERNATIVES. CROSS OUT THE TWO ALTERNATIVES NOT CHOSEN:*

- A) This power of attorney is effective immediately and is not affected by my subsequent disability or incapacity.
- B) This power of attorney becomes effective upon my disability or incapacity.
- C) This power of attorney becomes effective upon my voluntary or involuntary admission to a 24 hour care and treatment facility, or jail or other penal institution.

*You should cross out B) and C) if you want the power of attorney to become effective immediately. If neither (A), (B) nor (C) is crossed out, it will be assumed that you chose Alternative (A) and the power will become effective immediately.*

If I choose Alternative (B) above and a definition of my disability or incapacity is not contained in this power of attorney, then I shall be considered disabled or incapacitated for purposes of this power of attorney if a physician certifies in writing at a date later than the date this power of attorney is executed that, based on the physician's medical examination of me, I am mentally incapable of managing my financial and personal affairs. I authorize the physician who examines me for this purpose to disclose my physical or mental condition to another person for purposes of this power of attorney. A third party who accepts this power of attorney is fully protected from any action taken under this power of attorney that is based on the determination made by a physician of my disability or incapacity.

I agree that any third party who receives a copy of this document may act under it. Revocation of the durable power of attorney is not effective as to a third party until the third party receives actual notice of the revocation. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney.

If any agent named by me dies, becomes legally disabled, resigns, or refuses to act, I name the following (each to act alone and successively, in the order named) as successor(s) to that agent:

Name of 1st successor agent: \_\_\_\_\_  
complete address: \_\_\_\_\_

office, home, and cell phone numbers: \_\_\_\_\_

email address, if any: \_\_\_\_\_

Name of 2nd successor agent: \_\_\_\_\_ complete  
address: \_\_\_\_\_

office, home, and cell phone numbers: \_\_\_\_\_

email address, if any: \_\_\_\_\_

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
City, County, and State of Residence

STATE OF TEXAS  
COUNTY OF \_\_\_\_\_

This document was acknowledged before me on \_\_\_\_\_ (date) by  
\_\_\_\_\_ (name of principal(s)).

\_\_\_\_\_  
(signature of notary public)

\_\_\_\_\_  
(printed name)

My commission expires:  
\_\_\_\_\_

THE ATTORNEY IN FACT OR AGENT, BY ACCEPTING OR ACTING UNDER  
THE APPOINTMENT, ASSUMES THE FIDUCIARY AND OTHER LEGAL  
RESPONSIBILITIES OF AN AGENT.

**Notice of Power of Attorney:  
Care and Custody of Child, Children, and Ward**

**This form advises doctors and others of the fact that you have prepared a Power of Attorney for the emergency care of your Child, Children, or Ward. It is designed to fit in your wallet. Complete the information on the form, cut it out and keep it in your wallet.**

**DOCTORS AND OTHERS PLEASE NOTE:**

I have a Power of Attorney for the emergency care of my Child, Children, or Ward, which is a legal document stating my choice as to who may care for said child if I am unable to do so. A copy may be found at:

\_\_\_\_\_

The name of the person

is: \_\_\_\_\_ and can be

reached at: (day) \_\_\_\_\_ (evening) \_\_\_\_\_

If I am unable to make decisions, please call this person immediately.

My name: \_\_\_\_\_, My

SS# \_\_\_\_\_

This person is authorized to make all decisions stated in the Power of Attorney.