

LIMITED POWER OF ATTORNEY
for
EMERGENCY MEDICAL TREATMENT

Name of Dependent _____
Last First Middle

Date of Birth: _____ Age: _____ School Grade of Child: _____
(Month/Day/Year)

T-SHIRT SIZE (specify Youth or Adult) _____

Name of Parent or Legal Guardian: _____
Last First Middle Initial

"I hereby grant to Emma Ouellette, Maureen Klein, Matthew Jones, Wayne Cuthbert, Megan Cuthbert, John Kaneko, Carolyn Marengere, Tim Braun, Denise Church, Lyndsay Johnson-LeMieux, Anna Christie Smith, Carrie O'Riley, Jeff O'Riley, Matthew Carlson, William Drivinski, Samantha Martin, Michelle VanTuyl, Jessica Colvin, Anna Cloutier and to persons designated in writing by them, who serve as advisors for the Allen Park Presbyterian Church (USA), 7101 Park Avenue, Allen Park, Michigan 48101 (313-383-0100), the LIMITED POWER OF ATTORNEY to act for me and to give the required consents and authorizations for the delivery of necessary medical care, diagnoses, and treatment to the above-named child and to do all other necessary things as I might or could do if personally present.

"This LIMITED POWER OF ATTORNEY is given pursuant to the provision of State of Michigan P.A. 1978, NO. 642, Section 405 of the Probate Code; is intended to authorize the above-mentioned Advisors to act in my place and stead in all states of the United States and all provinces and territories of Canada; and is effective **from 11/1/11 thru 04/30/12**. I understand that one of the above-named Advisors will make repeated attempts to contact me prior to seeking any medical treatment for the above-named child except in situations that appear to be life-threatening. I agree that the Allen Park Presbyterian Church (USA), its employees, boards, ministers, and Advisors are free of any liability for decisions and /or actions taken in connection with this Limited Power of Attorney, and that I will accept responsibility for all expenses incurred for medical treatment for the above-named child."

Subscribed and sworn to before me
this _____ day of

_____, _____

Signature of Parent or Legal Guardian
(MUST be signed IN THE PRESENCE OF the Notary Public)

PRINT NAME Relationship to Child

Signature of Notary Public

_____, _____
Commission Expiration Date

Parent's/Guardian's Street Address

City, State, ZIP Code

MEDICAL INSURANCE INFORMATION

Family Physician _____

Physician Phone Number _____

Insurance Carrier _____

Policy Numbers _____

Name of Policy Holder _____

Verification Phone Number _____

Telephone (Area Code and Number)

Cell Phone

Parent E-mail

Youth E-mail

Back-up Contact Persons name and number(s)