INDIANA POWER OF ATTORNEY
FOR HEALTH CARE OF A MINOR DEPENDENT
PURSUANT I.C. 30-5-4-1 et seq.
Homes of Compassion, a Ministry of BCH, Inc.

Name of Minor Child:_____

Child's Date of Birth:_____

Child's Social Security Number:_____

Name of Parent(s)/Legal Guardian(s): _____

Name of Health Care Agent(s) (Homes of Compassion host parents):

_____

Date of Appointment:_____

Date of Termination (if applicable):_____

I/we, the biological parent(s)/legal guardian(s) of the above-named child, hereby appoint the health care agent(s) designated above (the "Health Care Agent(s)"), as my/our attorney-in-fact (my/our "agent" to act on my/our behalf in any way I/we could act in person) to make any and all decisions for me/us concerning my/our child's personal care and medical treatment, including but not limited to routine and ordinary care, evaluation, treatment, diagnostic evaluations of any sort, invasive and non-invasive procedures to the extent customarily used (of an emergency or non-emergency nature), in-patient or out-patient hospitalization, and all other health care, and to require, withhold or withdraw any type of medical treatment or procedure as I/we may want to require, withhold or withdraw for my/our child if I/we could act in person. My/our agent shall have the same access to medical records as I/we have, including the right to disclose the contents to others.

Parent/Legal Guardian: _____ *(Initial)*

Parent/Legal Guardian: ____ *(Initial)*

I/we specifically acknowledge and authorize our Health Care Agent(s) to assume the following medical care rights and responsibilities:

A. Physical Examination

I/we authorize our Health Care Agent(s) to consent to and obtain a physical examination for my/our child.

B. Routine and Ordinary Medical Care

I/we authorize our Health Care Agent(s) to consent to and obtain any routine or ordinary medical care for my/our child, including inoculations and immunizations. I/we also understand that staff will make a reasonable effort to contact me/us prior to such care but that failure to contact me/us will not be a reason to not obtain care for my/our child.

C. Diagnosis and Treatment

I/we authorize our Health Care Agent(s) to consent to and to obtain diagnosis and treatment for my/our child, whether invasive or non-invasive, as is deemed necessary and appropriate to prevent or care for any medical condition my child is reasonably believed to have or to alleviate my/our child's pain and suffering.

D. Extraordinary Medical Care

I/we authorize our Health Care Agent(s) to consent to and obtain any extraordinary medical care for my/our child including hospitalization, blood transfusion, surgery, and treatment in the event of a medical emergency which, in the opinion of the attending physician or health care provider, may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed. I/we also understand that staff will make a reasonable effort to contact me/us prior to such care, but that failure to contact me/us will not be a reason to deny treatment to my/our child.

E. Medical Card or Private Medical Insurance

If my/our child has a Medicaid card, I/we agree to give our Health Care Agent(s) the current card and will continue to provide the current card throughout the child's stay. If my/our child has private medical insurance, I/we will give our Health Care Agent(s) a copy of my/our insurance card and other pertinent information regarding such insurance and to pay any co-payments or other charges not covered by such insurance. If my/our child is not covered under an insurance plan either private or public, I/we agree to pay for any and all medical care that is required for my/our child. I/we also agree to pay all co-pays, deductible or other expenses not covered and/or reimbursed by insurance.

Applicable card numbers and providers:_____

_____

Parent/Legal Guardian: _____ *(Initial)*

Parent/Legal Guardian: ____ *(Initial)*

I/we direct my/our Health Care Agent(s) to take such action on behalf of my/our child as is reasonably necessary to alleviate suffering and to authorize any treatment as to which the potential and expected benefits outweigh the potential and expected burdens.

Parent/Legal Guardian: _____ *(Initial)*

Parent/Legal Guardian: ____ *(Initial)*

If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or become unavailable for any reason, I name the following as successors to such agent: BCH, Inc. (DBA Baptist Children's Home).

I/WE UNDERSTAND THIS IS A LEGAL DOCUMENT. I/WE AM/ARE FULLY INFORMED AS TO THE CONTENTS OF THIS DOCUMENT AND AM/ARE SIGNING THIS FORM VOLUNTARILY.

Notice: All parents/legal guardians must sign below and initial above as noted.

Signed _____ / _____
(*Parent/Legal Guardian)* *(Date)*

Signed _____ / _____
(*Parent/Legal Guardian)* *(Date)*

WITNESSED this _____ day of _____, ____.

_____
Witness

_____
(Printed Signature)

☐ *Copy of document provided to Biological Parent(s)/Legal Guardian(s) and Homes of Compassion Parent(s), with original placed into BCH/Homes of Compassion Parent file.*