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 Mike Hoffman, Jonathan Mallard, Ann Bleivik, Beckie Dicks, and to persons designated in writing by them, who serve as advisors for the First Presbyterian Church of Dearborn, 600 N. Brady, Dearborn, MI. 48124 (313-274-1313) 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 9/1/11 to 09/1/12.** I understand that one of the above-named adults 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 First Presbyterian Church of Dearborn (PC-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 Notary Public

_____, _____
Commission Expiration Date

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

_____
PRINT NAME Relationship to Child

_____
Parent's/Guardian's Street Address

_____
City, State, ZIP Code

_____
Telephone (Area Code and Number)

_____
Cell Phone

_____
Parent E-mail

_____
Youth E-mail

_____
Back-up Contact Persons name and number(s)

MEDICAL INSURANCE INFORMATION

Family Physician _____
Physician Phone Number _____
Insurance Carrier _____
Policy Numbers _____
Name of Policy Holder _____
Verification Phone Number _____