HEALTH CARE POWER OF ATTORNEY

(THIS FORM MUST BE COMPLETED & NOTARIZED FOR ALL SEVEN DAY BOARDERS)

I, _____, of _____, _____,
(Name of Parent/Guardian) (City) (State/Country)

is the parent/guardian of _____, a minor child. I hereby designate
(Name of Minor Child)

any Mount Michael Benedictine School representative to act as attorney-in-fact to make healthcare decisions on behalf of the minor child named above, including the power to consent to surgical operations, and other medical and dental treatment.

This delegation is made for a period of six months from the execution of this Power of Attorney.

This Power of Attorney shall not be affected by disability of the undersigned and shall remain in effect to the extent permitted by law, notwithstanding later disability or inability of the undersigned, or a later uncertainty as to whether the undersigned may be dead or alive.

DATED: _____

_____
(Signature of Parent/Guardian)

_____
(Printed Name of Parent/Guardian)

STATE OF _____)
) SS
COUNTY OF _____)

Before me, a Notary Public qualified in and for said County, personally came _____, known to me to be the identical person who signed the foregoing instrument and he acknowledged the execution thereof to be his voluntary act and deed.

WITNESS my hand and Notarial Seal on _____.

_____
Notary Public