

MEDICAL POWER OF ATTORNEY

From

Full Name(s) of Parents(s) or Guardian

To

TUSCARORA HIGH SCHOOL

We (I) _____
(Full Name(s) of Parents(s) or Guardian)

of _____
(Residential Address in Full)

do hereby appoint Tuscarora High School our true and lawful attorney in fact, with full power in loco
parentis, to decide upon and consent to the rendering of any medical diagnosis and treatment, including surgery, which THEY deem(s)
in the best interest of the health and welfare of our child (or children) _____
(Insert Names of the Child of Children)

This power of attorney shall be effective during such period of time as we, or either of us, may for any reason not be available to give our consent
to any medical diagnosis or treatment, including surgery, for our child (children).

This power of attorney shall not be affected by the disability of either or both of us, but shall continue in full force and effect during any such
disability.

Executed this _____ day of _____, 20_____.

WITNESS:

(Signature of Parent or Guardian)

(Name and Address of Witness) (Signature of Parent or Guardian)

(Name and Address of Witness)

GENERAL INFORMATION ABOUT CHILD (If children, clearly identify the information with reference to the specific child)

Existing Medical Problems: _____

Child's Allergies, if any: _____

Parent's Doctor: _____

Child's Doctor: _____

Choice of Specialists: _____

Medicines Child is Taking: _____

Insurance Company Information: _____

*** Please attach a copy of your insurance card.**