CONSENT TO MEDICAL TREATMENT

I/we, _____, parent(s) or guardian(s) of the below named child, hereby grant to The First Baptist Church of Rogers, Arkansas and any employee of the Church who identifies themselves as such with an employee badge or business card and personal driver's license (hereinafter "my agent") a limited power of attorney to obtain medical attention for my below named child in the event that I am not present to consent to the same. My desire in granting this limited power of attorney is to provide for the immediate health care needs of my child in between the time of his or her need and my arrival at the medical facility to take over the health care decisions concerning my child.

My agent may determine and implement all actions necessary for the medical treatment and care of my below named child, including but not limited to the items specifically mentioned in this instrument. I instruct my agent to make the choice for healthcare for my below named child based on what my agent believes to be in my child's best interests, taking into account the provisions of this instrument, consultation with me by phone if I am available, and any information given to my agent by the physicians treating my child as to his or her medical diagnosis and prognosis and the intrusiveness, pain, risks, and side effects of the treatment.

Acting on my behalf, my agent may have access to all of my below named child's medical information and may disclose medical and related information concerning my below named child's treatment to appropriate health care providers and may admit or transfer my below named child to such hospitals or treatment facilities as my agent determines to be in the best interests of my below named child. In order for my agent to fulfill his, her, or its duties, my below named child's treating physician or hospital is to discuss my child's medical condition with and disclose all medical records to my agent. My agent may employ medical personnel as my agent determines necessary for my below named child's physical well-being.

I want to ensure that my agent and my below named child's physician protect my child's comfort and freedom from pain insofar as possible. I authorize my agent to consent on my behalf to the administration of whatever pain-relieving drugs my agent, upon medical advice and consultation with me by phone if I am available, believes may provide comfort to my child, even though such drugs may lead to addictions, low blood pressure, lower levels of breathing, or allergic reactions.

My agent may grant, in conjunction with any instructions given under this instrument, releases from all liability for damages suffered or to be suffered by me to hospital staff, physicians, nurses, and other medical and hospital administrative personnel who act in reliance on instructions given by my agent or who render written opinions to my agent in connection with any matter described in this instrument. My agent's instructions and decisions regarding my below named child's medical treatment are binding on third parties. No person, medical facility, or institution will incur any liability to me or to my child's estate by complying with my agent's instructions. My agent is authorized to execute consents, waivers, and releases of liability on my behalf, on behalf of my child, and on behalf of our estates to all medical personnel who comply with my agent's instructions. Furthermore, I authorize my agent to indemnify and hold harmless, at my expense, any third party who accepts and acts under this instrument, and I agree to be bound by any indemnity entered into by my agent. My agent will not incur any personal liability

to me or my estate arising from the good faith exercise of discretion or performance of acts and duties relating to the medical treatment of my below named child. My agent is entitled to reimbursement for all reasonable expenses arising from the good faith performance of the acts and duties relating to the medical treatment of my below named child under this instrument.

Where context requires, the singular herein may be read as plural and vice versa, and the masculine may be read as feminine and vice versa, as necessary.

Photocopies, facsimiles, and digital representations of this instrument are effective and enforceable as originals. Any one of the below signed may make amendments by appendix to this instrument to the medical information below without further need of notarization but requiring my signature and date thereof. My agent and any healthcare provider to which this power of attorney is presented may further rely on and utilize the following information and any such appendix in furtherance of the purposes of this instrument:

My Child's Name: _____ Date of Birth: _____

My Child's SSN: _____ Policy Owner SSN: _____

Policy Owner Name: _____ Date of Birth: _____

Insurance Carrier: _____ Group Number: _____

Insurance Contact: _____

My Phone Number(s): _____

My Child's Medications: _____

_____

My Child's Allergies: _____

_____

My Child's Primary Care Physician: _____ Phone: _____

Address: _____

Please check if your child has had any of the following:
Measles _____ Mumps _____ Chicken Pox _____ Whooping Cough _____
Frequent Ear Infections _____ German Measles _____ Fainting Spells _____
Contracted Tuberculosis _____ Diabetes _____ Biting _____ Seizures _____
Sun Sensitivity _____ Hearing Loss or Difficulties _____ Speech Difficulties _____

Other Medical Concerns: _____

_____

_____

The below signed is/are: (check one) _____ the sole custodian or legal guardian of the above named child _____ joint custodians or legal guardians of the above named child (if joint custodians or legal guardians, both must sign before a notary).

_____ _____

PARENT SIGNATURE DATE

_____ _____

PARENT SIGNATURE DATE

ACKNOWLEDGMENT

STATE OF ARKANSAS §
§ ss:
COUNTY OF _____ §

SWORN TO and SUBSCRIBED before me, a duly acting notary public for the State and County aforesaid, this _____ day of _____, 20____.

_____

NOTARY PUBLIC

My Commission Expires: _____