SPECIAL LIMITED POWER OF ATTORNEY FOR MEDICAL AUTHORIZATION

I, _____, a resident of Cherokee County, Georgia, hereby appoint the following person(s) as my attorney(s) in fact: Print Names: _____

_____ _____

_____ _____

_____ _____

_____ to act in my capacity and make any and all decisions and authorize all procedures that such individual may deem necessary regarding the medical treatment of my child _____. The rights, powers, and authority of my attorney(s) in fact to exercise any and all of the rights and powers herein granted shall commence and be in full force and effect upon the execution of this document and shall remain in full force and effect until May 31, 2017 or unless specifically extended or rescinded earlier by either party.

Dated:_____, 2017

Signed:_____ Parent or legal guardian of the above-listed child

STATE OF GEORGIA, COUNTY OF CHEROKEE BEFORE ME, the undersigned authority, on this _____day of _____, 2017, personally appeared _____to me well known to be the person described in and who signed the foregoing and acknowledged to me that he/she executed the same freely and voluntarily for the uses and purposes therein expressed. WITNESS my hand and official seal the date aforesaid. NOTARY PUBLIC

Signed:_____ My Commission Expires:_____