LIMITED POWER OF ATTORNEY

INSTRUCTIONS

The parent or legal guardian (Principal) should fill out the form on pages 11-12 to give a third party (Attorney-in-Fact) general power to make the majority of decisions and to do the majority of things that a parent would do for their child.

1. You should make copies of this form once it is signed. Use the copies whenever possible in order to protect the original.
2. The form should be signed by the parent or parents with legal custody or the legal guardian. Both parents should sign if the child is living with both parents.
3. A different Limited Power of Attorney form should be completed for each child in the family.
4. Due to travel problems of taking a child to another country, the parents may want to sign a Limited Power of Attorney making the other parent the Attorney-in-Fact, along with a Limited Power of Attorney making another trusted family member or friend an Attorney-in-Fact.
5. The parent or parents must sign the form in front of a notary public. If you did not sign the Limited Power of Attorney form prior to being arrested or detained, you can ask jail staff to help find a notary in the jail. Every bank has a notary public. You should not have to pay a high fee.
6. This form may not be honored or recognized by all persons, governmental organizations, or businesses.
7. If you sign the Limited Power of Attorney form in advance, you will have to re-sign it if you place an expiration date on it.
8. The Limited Power of Attorney form is only a short-term solution to a parent or parents being arrested and detained by the government. The Attorney-in-Fact will need to consult with an attorney regarding child custody if the child's parent or legal guardian is detained.

LIMITED POWER OF ATTORNEY FOR CHILD AND MEDICAL CARE, ACCESS TO EDUCATIONAL RECORDS, AND AUTHORITY TO MAKE EDUCATION DECISIONS

Principal / Parent

Name: _____

Date of Birth: _____

ID Type: _____

ID Number: _____

Principal / Parent

Name: _____

Date of Birth: _____

ID Type: _____

ID Number: _____

Child

Name: _____

Date of Birth: _____

SSN: _____

Passport Number: _____

Attorney-in-Fact

Name: _____

Date of Birth: _____

Address: _____

_____

I/We, _____ and _____, presently residing at _____, as the parent(s)and/or custodian(s) of _____, hereinafter referred to as the **child**, hereby delegate to _____, hereinafter referred to as my/our **Attorney-in-Fact**, the authority to act in my/our place and stead with respect to each of the following powers pursuant to Ohio Revised Code Chapter 1337:

1. To consent to any necessary medical treatment, surgery, medication, therapy, hospitalization or other such care of or for the child;
2. To employ, retain or discharge any person who may care for, counsel, treat or in any manner assist the child;
3. To receive Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA) about my/our child, including release of records;
4. To obtain copies of my/our child's educational records kept in any of my/our child's educational files. I/we waive and release educational institutions from any restrictions imposed by law in disclosing or revealing any educational record, including, but not limited to, the Family Educational Rights and Privacy Act, 20 U.S.C. 1232g and Ohio Revised Code Section 3319.321;
5. To participate in any educational decisions about my/our child as if the designated Attorney-in-Fact herein was a parent or guardian of the child. I/we waive and release educational institutions from any restrictions imposed by law in determining who may make educational decisions for my/our child, including, but not limited to, the Family Educational Rights and Privacy Act, 20 U.S.C. 1232g and Ohio Revised Code Chapter 3319;
6. To drop off or pick up my/our child from school or approve travel that is part of my/our child's education. I/we waive and release educational institutions from any restrictions imposed by law in determining who may pick up or drop off my/our child at school or approve travel for educational activities;

7. To exercise the same parental rights I/we may exercise with respect to the care, custody and control of the child and the discretion to exercise the same rights in my/our Attorney-in-Fact's home or any other place selected by my/our Attorney-in-Fact in his/her discretion;
8. To authorize and consent to travel with child to and from the United States of America, and within _____; and,
9. To perform all other acts necessary, or incidental to the execution of the powers enumerated herein.

I/We also recommend and consent to the appointment by the Juvenile Court of my Attorney-in-Fact as legal custodian in the event that I/we are out-of-state for 30 days or more.

Any lawful act performed by my/our agent shall be binding upon myself/ourselves, my/our heirs, beneficiaries, personal representatives and assigns. I/We reserve the right to amend or revoke this Limited Power of Attorney at any time hereafter; provided, however, any institution or other party dealing with my agent may rely upon this Limited Power of Attorney until receipt by it of a duly executed copy of my/our revocation thereof.

Any reproduced copy of this signed original shall be deemed to be an original counterpart of this Limited Power of Attorney. This Limited Power of Attorney shall not be affected by any legal incapacity during my/our lifetime, except as provided by statute.

This Limited Power of Attorney shall remain in effect from the date of signing and terminate upon a subsequent written revocation or on _____, whichever shall occur first.

Dated: _____

Signature(s): _____ _____

STATE OF OHIO)

COUNTY OF _____)

On this _____ day of _____, 20___, before me, a Notary Public in and for said County and State, personally came _____ and acknowledged the signing of the foregoing instrument, and that the same is his/her/their voluntary act and deed.

IN TESTIMONY WHEREOF, I have hereunto subscribed my name and affixed my notarial seal on the day and year first above written.

_____ My Commission Expires: _____

Notary Public

(SEAL)

IMPORTANT TELEPHONE NUMBERS & INFORMATION

IN CASE OF EMERGENCY, CALL 911

Police:

Fire:

Consulate of my Country:

FAMILY/IMPORTANT CONTACTS IN THE U.S.

Name:

Phone:

Cell:

Work:

Relationship:

Name:

Phone:

Cell:

Work:

Relationship:

FAMILY/IMPORTANT CONTACTS IN MY HOME COUNTRY

Name:

Phone:

Cell:

Work:

Relationship:

Name:

Phone:

Cell:

Work:

Relationship:

INSURANCE INFORMATION

Health Insurance

Company:

Phone:

Policy #:

Car Insurance

Company:

Phone:

Policy #:

Car 1:

VIN #/Plate #:

Car 2:

VIN #/Plate #:

Home Insurance

Company:

Phone:

Policy #:

MEDICAL INFORMATION

Doctor:

Phone:

Dentist:

Phone:

Pediatrician:

Phone:

Hospital:

Phone:

Pharmacy:

Phone:

IMPORTANT FAMILY RECORDS

Use this form in order to have all important information in the same place. Put originals of each document in a safe place (e.g. lock box).

WORK NUMBERS

Employer #1

Name:

Phone:

Supervisor:

Date Started:

Union Rep:

Phone:

Employer #2

Name:

Phone:

Supervisor:

Date Started:

Union Rep:

Phone:

INFORMATION ABOUT YOUR VEHICLES

Vehicle 1 Make/Model:

Plate #:

VIN/ID #:

Car Loan:

Insurance:

Vehicle 2 Make/Model:

Plate #:

VIN/ID #:

Car Loan:

Insurance:

Attach a copy of each vehicle's registration and insurance and a photograph of each vehicle.

SCHOOL/DAYCARE NUMBERS

School #1

Name of School:

School ID Number:

Phone:

Name of Child:

Name of Teacher:

Name of Child:

Name of Teacher:

School #2

Name of School:

School ID Number:

Phone:

Name of Child:

Name of Teacher:

Name of Child:

Name of Teacher:

SOCIAL SECURITY #/ITIN

Name:

Number:

Name:

Number:

Name:

Number:

Name:

Number:

Attach a copy of each social security card.

FAMILY MEDICAL INFORMATION & IDENTIFICATION

Attach a copy of birth certificate, record of vaccination, and photos of each family member.

FAMILY MEMBER #1

Name:

Date of Birth: Organ Donor: Yes No

Allergies:

Medications:

Medical Conditions & Medical History:

FAMILY MEMBER #2

Name:

Date of Birth: Organ Donor: Yes No

Allergies:

Medications:

Medical Conditions & Medical History:

FAMILY MEMBER #3

Name:

Date of Birth: Organ Donor: Yes No

Allergies:

Medications:

Medical Conditions & Medical History:

FAMILY MEMBER #4

Name:

Date of Birth: Organ Donor: Yes No

Allergies:

Medications:

Medical Conditions & Medical History:

FAMILY MEMBER #5

Name:

Date of Birth: Organ Donor: Yes No

Allergies:

Medications:

Medical Conditions & Medical History:

FAMILY MEMBER #6

Name:

Date of Birth: Organ Donor: Yes No

Allergies:

Medications:

Medical Conditions & Medical History:

FAMILY MEMBER #7

Name:

Date of Birth: Organ Donor: Yes No

Allergies:

Medications:

Medical Conditions & Medical History:

PERSONS WHO CAN PICK UP MY CHILDREN FROM SCHOOL/DAY CARE

Name:	Name:
Date of Birth:	Date of Birth:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Relationship:	Relationship:

PERSONS WHO CANNOT PICK UP MY CHILDREN FROM SCHOOL/DAY CARE

Name:

Name:

Name:

Please inform personnel at your children's school that the persons listed in these sections have permission to pick up your children or do not have permission. ***If there is a restraining order, attach a copy of the order and file another copy with the school and/or daycare of your children.

CONTACTS FOR LEGAL PROBLEMS, IDENTITY THEFT, & FRAUD

For your security DO NOT note the numbers of your credit cards or account numbers on this document.

CREDIT CARD COMPANIES

Card #1

Company:

Toll-Free Number:

Names on Card:

Card #2

Company:

Toll-Free Number:

Names on Card:

Card #3

Company:

Toll-Free Number:

Names on Card:

Report theft of credit cards IMMEDIATELY!

CIVIL LEGAL ASSISTANCE

Legal Aid:

Immigration Attorney:

Other Attorney:

CONTACTS FOR FINANCIAL AFFAIRS

Checking Account #1

Bank:

Toll-Free Number:

Persons with Access:

Checking Account #2

Bank:

Toll-Free Number:

Persons with Access:

Savings Account #1

Bank:

Toll-Free Number:

Persons with Access:

Savings Account #2

Bank:

Toll-Free Number:

Persons with Access:

PUBLIC AGENCY CONTACTS

Domestic Violence Help:

Public Prosecutor:

Report Child Abuse:

EMERGENCY CARE FOR PETS

PET #1

Name:

Date of Birth:

Breed:

Description:

Registration Number:

Medications:

Medical Problems:

PET #2

Name:

Date of Birth:

Breed:

Description:

Registration Number:

Medications:

Medical Problems:

VETERINARIAN

Name:

Phone:

Address:

Emergency Phone:

EMERGENCY HOUSING FOR PETS

Name:

Phone:

Address:

Attach a photograph of each pet.