Virginia Physicians, Inc.

# Authorization to Consent to Health Care for Minor

I,_____, of_____County, State of

_____, am the custodial parent having legal custody of

_____, a minor child, age _____, born on

_____. I authorize **Ashland Medical Center,** of Hanover County, in the

State of Virginia, to do any acts which may be necessary or proper to provide for the health care of the minor child, including, but not limited to the power (I) to provide such health care at any hospital or other institution, or the employing of any physician, dentist, nurse or other person whose service may be needed for such health care, and (ii) to consent to and authorize any health care, including administration or anesthesia, X-Ray examination, performance of operations and other procedures by physicians, dentists and other medical personnel, except the withholding or withdrawal of life sustaining procedures.

This consent shall be effective from the date it is executed until the date I terminate it in writing.

By signing here, I indicate the (i) I have the understanding and capacity to recognize the importance of, to communicate and to assign the health care decisions covered by this document, (ii) I am fully informed as to the contents of the document, and (iii) I understand the full scope and importance of this grant of powers to the agent named herein.

_____ _____

**Custodial Parent's Signature** **Date**