

**POWER OF ATTORNEY AND DELEGATION OF AUTHORITY BY
PARENT CONCERNING MINOR CHILD (complete one for each child)**

This Power of Attorney is made on _____ (Month) _____ (Day), 20 _____.

BETWEEN:

PARENT/GUARDIAN(S):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Whose address and telephone number are: _____

Who state there is no court order or other legal prohibitions now in effect that would prevent him/her/them from exercising this authority,

AND ATTORNEY IN FACT:

_____,
(Name)

Whose address and telephone number are: _____

If only one parent is signing, or if a nonparent custodian who shares custody with a parent is signing but the parent is not, please check off reason:

☐ Death of one parent.

☐ Custody has been removed by a court of law.

☐ Mentally or physically unable to give consent.

☐ The parent has not been involved in raising or financially supporting the child for two years or a third of the life of the child, whichever is less, immediately preceding the date of the latest signature below.

☐ The identity or whereabouts of such parent are unknown to me.

☐ Despite diligent efforts described below, I was unable to reach such parent.

Diligent efforts included:

Other, please explain:

I/we appoint said Attorney-in-Fact, pursuant of the provisions of N.J.S.A. 3B: 12-39, and delegate of said Attorney-in-Fact the following powers concerning the care, custody and property of my/our child/minor ward.

_____ (“the child”), born
on _____ day of _____ of 20____.

Care-Giving. The Attorney-in-Fact shall have temporary care-giving authority for the child/minor ward, until such time as the child/minor ward is returned to our/my physical custody, or his/her custody status is altered by a federal, state, or local agency; or changed by a court of law.

Well-Being. The Attorney-in-Fact shall have the power to provide for the child's/minor ward's physical and mental well-being, including but not limited to, providing food and shelter.

Education. The Attorney-in-Fact shall have the authority to enroll the child/minor ward in the appropriate educational institutions; obtain access to his/her school records; authorize his or her participation in school activities; and make any and all decisions related to his or her education, including, but not limited to, those related to special education.

Health Care. The attorney in fact shall have the authority, to the same extent that a parent/custodian/guardian would have the authority, to make medical, dental, and mental health decisions; to sign documents, waivers and releases required by a hospital or physician; to access medical, dental, or mental health records concerning the child/minor ward; to authorize the child's/minor ward's admission to or discharge from any hospital or medical care facility; to consult with any provider of health care; to consent to the provision, withholding, modification or withdrawal of any health care procedure; and to make other decisions related to the child's/minor ward's health care needs.

Travel. The Attorney-in-Fact shall have the authority to make travel arrangements on behalf of the child/minor ward for destinations both inside and outside of the United States by air and/or ground transportation; to accompany the child/minor ward on any such trips; and to make any and all related arrangements on behalf of the child/minor ward, including, but not limited to, hotel accommodations. The Attorney-in-Fact shall also have the power to request the Brazilian Consulate to issue passports and any necessary travel documents for the child/minor ward.

Financial Interests. The Attorney-in-Fact may handle any and all financial affairs and any and all personal and legal matters concerning the child/minor ward.

All Other Powers. The Attorney-in-Fact shall have the authority to handle and engage in any and all other matters relating to the care, custody and property of the child/minor ward which are permitted pursuant to applicable state law.

By this delegation, I/we provide that the Attorney-in-Fact's authority shall take effect upon the following activating event(s). Check all that apply:

☐ The execution of this document on the latest date below; or

☐ My attending physician concludes that I am incapacitated, and thus unable to care for my child/minor ward; or

☐ My attending physician concludes that I am physically debilitated, and thus unable to care for my child/minor ward; or

☐ I am detained in immigration detention, removed, or deported; or

☐ I am incarcerated based on criminal charges, including pending charges, or conviction; or

☐ I am deployed in military service; or

☐ Upon my death, if I have made no more permanent care arrangements for my minor child/minor ward; or

☐ Other (specify reason).

In the event that the person designated above is unable or unwilling to act as Attorney-in-Fact to my child/minor ward, I hereby name:

(put name, address, and telephone number of alternate Attorney-in-Fact), as alternate Attorney-in-Fact to my child/minor ward.

I/we understand that this delegation will expire in six months from the execution of this document on the latest date below, and that the authority of the Attorney-in-Fact, if any, will cease, unless by that date (i) I renew this delegation, by the same process applicable to the original delegation, or; (ii) a court of competent jurisdiction appoints a custodian, guardian, or standby guardian for the child/minor ward; or (iii) exigent circumstances make it impossible for me to renew this delegation, and I have not made alternative care arrangements for my child/minor ward.

I/we hereby authorize that the Attorney-in-Fact as set forth above shall be provided with **a copy of my/our attending physician's statement (s), if applicable.**

In the event that an activating event occurs and a Power of Attorney is activated pursuant to this statement, I declare that it is my intention to retain full parental rights to the extent consistent with my condition and circumstances and, further, that **I retain the authority to revoke the Power of Attorney consistent with my rights herein at any time.**

Signature of Mother
Name of the mother

Date of Signature

Signature of Father Parent/Guardian #2
Name of the father

Date of Signature

Signature of Attorney in Fact
Name of the Attorney in Fact

Date of Signature

Witness Signature #1

Date of Signature

Witness Signature #2

Date of Signature

STATE OF NEW JERSEY :

ss.:

COUNTY OF _____ :

BE IT REMEMBERED, that on _____ (Month), _____, 20 _____, before me, the subscriber, a Notary Public of the State of New Jersey, personally appeared

_____, who, I am satisfied, is the person named in and who executed the foregoing Durable Power of Attorney, and he/she did acknowledge that he/she executed it as his/her voluntary act for the uses and purposes expressed therein.

Notary Public

STATE OF NEW JERSEY :

ss.:

COUNTY OF _____ :

BE IT REMEMBERED, that on _____ (Month), _____, 20 _____, before me, the subscriber, a Notary Public of the State of New Jersey, personally appeared

_____, who, I am satisfied, is the person named in and who executed the foregoing Durable Power of Attorney, and he/she did acknowledge that he/she executed it as his/her voluntary act for the uses and purposes expressed therein.

Notary Public