**Delegation of Parental Authority**

{{ i\_we }}, {{ users[0] }}{% if users.number\_gathered() == 2 %} and {{ users[1] }}{% endif %}, wish to temporarily leave {{ my\_our }} minor {{ child\_or\_children }}, in the care and custody of {{ caregivers[0] }}, who lives at {{ caregivers[0].address.on\_one\_line() }}.

{{ i\_we }} appoint and vest in {{ my\_our }} Agent full powers as a substitute parent, giving them the authority to do anything and everything required for {{ my\_our }} {{ child\_or\_children }}’s care. {{ i\_we }} also authorize {{ my\_our }} Agent to do any of the things that {{ i\_we }}, as a parent, could do on behalf of {{ my\_our }} {{ child\_or\_children }}. {{ i\_we }} specifically authorize {{ caregivers[0] }} to:

1. Consent to medical and/or dental care for {{ my\_our }} {{ child\_or\_children }};
2. Enroll {{ my\_our }} minor {{ child\_or\_children }} in appropriate schools and/or educational programs;
3. Act or consent to any and all acts with respect to {{ my\_our }} {{ child\_or\_children }}’s health and well-being, except the power to consent to guardianship, adoption, or marriage.

{% if military == “yes” %}I am a service member on deployment to a foreign country. Pursuant to MCL 700.5103(3), this delegation of parental powers will remain in effect while I am deployed in a foreign country{% if military\_end\_date == “specific date” %} until {{end\_date}}{% elif military\_end\_date == “31\_days\_post\_return” %} and for 31 days after I return from the foreign deployment{% endif %}, or on my declaration, whichever comes first. {% elif military == “no” %}This delegation of parental powers is given pursuant to MCL 700.5103, and will become effective on {% if effective\_date == "date\_signed" %}the day {{ i\_we }} sign it{% elif effective\_date == "specific\_start\_date" %}{{ effective\_date }}{% endif %}. This power expires {% if civilian\_end\_date == "6 months" %}six (6) months from the date it begins {% elif civilian\_end\_date == "specific date" %}on {{ end\_date }} {% endif %}or on my declaration, whichever comes first.{% endif %}

This delegation of parental authority was signed on \_\_\_\_\_\_\_\_\_\_\_\_\_.

Signature of Parent{% if users.number\_gathered() == 2 %}s{% endif %}:

/s/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ {% if users.number\_gathered() == 2 %}/s/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

{% endif %}

{{ users[0] }} {% if users.number\_gathered() == 2 %}{{ users[1] }}

{% endif %}

NOTE: **Michigan does not require this document to be witnessed and notarized**. If you wish to have this form witnessed and notarized, do so here:

Witnesses:

/s/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ /s/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name of witness 1, if any: Print name of witness 2, if any:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STATE OF MICHIGAN )

\_\_\_\_\_\_\_\_\_\_\_\_ COUNTY )

Acknowledged before me and the witnesses, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in \_\_\_\_\_\_\_\_\_\_\_ County, Michigan, on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by {{ users[0] }}{% if users.number\_gathered() == 2 %} and {{ users[1] }}{% endif %}.

/s/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary public: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State of Michigan, County of \_\_\_\_\_\_\_\_\_\_\_\_\_.

My commission expires\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Health Information Addendum**

**Health Insurance Information**

{{ my\_our }} health insurance carrier is {{ insurance\_companies[0] }}, member ID/policy number: {{ insurance\_companies[0].policy\_number }}, group number: {{ insurance\_companies[0].group\_number }}.

**Hospital Preference**

{% if preferred\_hospital == True %}{{ hospitals[0] }}

{{ hospitals[0].address.on\_one\_line() }}

{% else %}No Hospital Preference{% endif %}

**Health Care Providers**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of provider** | **Provider Name** | **Address** | **Phone number** |
| {{ providers[0].provider\_type }} | {{ providers[0] }} | {{ providers[0].address.block() }} | {{ providers[0].phone\_number }} |

**Information about Medical Conditions**

{{ children[0] }} is allergic to: {{ children[0].allergies }}.

{{ children[0] }} has the following medical conditions: {{ children[0].health\_conditions }}.

{{ children[0] }} takes the following medications: {{ children[0].medications }}.

{{ children[0] }} may not have the following medications: {{ children[0].bad\_meds }}.

Other health information about {{ children[0] }}: {{ children[0].other\_health\_info }}