Sunburst Youth Academy

Special Power of Attorney for the Authorization of Medical Care and Medical Expense Statement
THIS FORM NEEDS TO BE NOTARIZED

KNOWN ALL MEN/WOMEN BY THESE PRESENTS:

That I_Parent/Guardian Name_____, Date of birth ____/____/____ ID # _Parent/Guardian ID#_____
Guardian (or Applicant if 18 years old) Parent/Guardian DOB *(Guardian's, or Applicant's if 18 years old, identification number)*

am a legal resident of_____County of Residence_____ County, California, hereby appoint the director of Sunburst Youth
(Name of County)
Academy, located at Los Alamitos Joint Forces Training Base, Los Alamitos, CA, as my true and lawful attorney-in-fact to do the following in my name and in my behalf:

Anything necessary to maintain (my health) the health of my child*, _____Student's Name_____. I want my attorney-in-fact to
***If 18 years old enter "N/A".**
have the power to consent to any medical or dental treatment needed for my child and to sign any papers needed to authorize those treatments. I want my attorney-in-fact to be able to do anything I could do if I were personally present. Anything my attorney-in-fact does to maintain the health of my child (my health) will be the same as if I had done it myself. This is a Durable Power of Attorney. It will stay in effect if I become disabled, incapacitated or incompetent. This Power of Attorney shall expire after the 22 week residential phase is completed or the Cadet withdraws or is terminated from the Academy.

Medical Expenses Statement of Understanding

The medical staff at the Sunburst Youth Academy consists of a Medical Doctor, P.A, and RNs. They will make all necessary medical determinations regarding current cadets. Sunburst Youth Academy **DOES NOT** pay for normal medical expenses incurred by your cadet. The cadet, and ultimately the parent/guardian, regardless of insurance coverage, is responsible for all normal medical and dental expenses, to include all co-payments, deductibles, and all non-covered charges. The Academy will provide physician, hospital, or pharmacy needs with the appropriate insurance information or Medical or Medicaid coverage.

IN WITNESS WHEREOF, I have affixed my signature hereto this _____day of _____20_____

☐ **Signature**_____Sign in front of notary_____
Guardian (or Applicant if 18 years old)

********** TO BE COMPLETED BY NOTARY **********

STATE OF CALIFORNIA, COUNTY OF _____Notary will complete this section_____)

On _____ before me, _____,

personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS My hand and official seal.

Notary Public will sign this document and stamp HERE.

☐ **Signature:** _____ **(Seal)**