

**DELEGATION OF POWER BY PARENT OR GUARDIAN  
PURSUANT TO §15-14-105, C.R.S.**

I, \_\_\_\_\_ (full name), parent or guardian of the minor child(ren) or incapacitated person(s) named below:

Full Name of Child or Incapacitated Person	Date of Birth	Relationship

I hereby authorize and appoint \_\_\_\_\_ (name of person), as Attorney in Fact for me with full authority to act in my place as follows:

1. To perform any and all acts necessary for the day-to-day care, custody, education, recreation, and property of the above-named minor child or incapacitated person, consistent with the provision of §15-14-105, C.R.S.
2. To authorize any and all medical and dental care for the health and well being of the minor child(ren) or incapacitated person(s). This care includes, but is not limited to medical and dental exams and tests, x-rays, surgeries, anesthesia, and hospital care.

This Special Power of Attorney does not give the Attorney in Fact the power to consent to the marriage or adoption of the child or incapacitated person.

This Special Power of Attorney shall be effective until \_\_\_\_\_ unless revoked earlier by the parent or guardian in writing. In any case, the authority granted herein shall not be valid for more than twelve (12) months from the date of this document.

Date: \_\_\_\_\_  
\_\_\_\_\_  
Parent/Guardian Signature

This document was signed by \_\_\_\_\_ (Parent/Guardian Name) in my presence, and in the presence of each other, have signed below as witness. I declare that, at the time the Parent/Guardian signed this document, I believe that he or she was of sound mind and under no pressure or undue influence. I am at least 18 years of age.

APPOINTED ATTORNEY IN FACT CANNOT SIGN AS WITNESS.

\_\_\_\_\_  
 Signature of Witness

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name

\_\_\_\_\_  
 Address

\_\_\_\_\_