**POWER OF ATTORNEY**

I, , of Marion County, State of Indiana, being a mentally competent adult, do hereby designate and appoint of Marion County, State of Indiana, as my true and lawful Attorney-in-Fact, with full authority and power to act on my behalf, as set out in this document, with respect to my minor children . I am the custodial (Mother/Father) of , and have legal authority to act on their behalf.

I hereby revoke all powers of attorney heretofore granted by me to individuals to make decisions on behalf of and terminate all agency relationships created under any such prior powers, including those of all successor agents named or contemplated therein, if any.

My Attorney-in-Fact is authorized, in her sole and absolute discretion, to exercise all powers with respect to, and to perform all actions and exercise all powers required or useful to seek, obtain, authorize, provide, initiate, and maintain for , including any and all of the following:

(1) Medical, optical, dental, hospital, therapeutic, emergency or immediate care or services;

(2) Education and related services, including, but not limited to, enrollment in public or private school(s);

(3) Social Security, TANF, food stamps, Medicaid, Hoosier Healthwise, or any other governmental benefits.

(4) Authority to take the children across Indiana State lines.

(5) Any other action, benefit, service, or power that, in her sole and absolute discretion, is necessary or beneficial for the children’s care or well-being.

This Power of Attorney, and all actions taken by my Attorney-in-Fact as authorized hereunder, shall be binding upon me and my heirs, successors, assigns, legatees, guardians, and personal representatives, and I hereby ratify and confirm all such acts. This Power of Attorney shall remain in full force and effect until specifically revoked by me in a signed writing, and shall not be affected by the fact that I may become incompetent hereafter. Otherwise, this power shall remain in effect until the children reach the age of majority. No person who relies in good faith upon any representations by or authority of my Attorney-in-Fact under this Power of Attorney shall be liable to me or my estate, heirs, or assigns for recognizing or relying upon such representations or authority.

This Power of Attorney is intended to be valid and given full faith and credit in any jurisdiction or state in which it is presented. If any part or provision of this Power of Attorney is deemed invalid or unenforceable by a court, such part or provision shall be ineffective only to the extent of such specific invalidity or unenforceability, without in any way affecting the remaining parts or provisions hereof.

My Attorney-in-Fact is authorized to make photocopies of this instrument as frequently and in such quantity as she deems appropriate. Any photocopy of this Power of Attorney shall have the same force, validity, and effect as the original.

IN WITNESS WHEREOF, I have executed this Power of Attorney on and as of the date set forth below.

Date

STATE OF INDIANA )

 )SS:

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

Subscribed to and sworn before me, a Notary Public, in and for the State of Indiana this\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_.

My commission expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Notary Public (Signature)

 My County of Residence:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Name Printed