Durable Power of Attorney for Health Care

A health care power of attorney pursuant to SDCL 59-7-2.5 et seq. may, but need not be, in the following form:

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, being an adult of sound mind, hereby appoint
(name of principal)

_____, of _____
(name of agent) (his/her address and telephone number)

as my attorney-in-fact ("agent") to consent to, to reject, or to withdraw consent for medical procedures, treatment, or intervention. In the event the person I appoint above is unable, unwilling or unavailable to act as my health care agent, I appoint as my successor agent:

_____, of _____
(name of successor agent) (his/her address and telephone number)

My agent (or any successor agent) may make any health care decisions for me which I could make individually if I had decisional capacity (except for any limitations given below). All such decisions shall be made in accordance with accepted medical standards and the agent (or any successor agent) may not authorize the withholding or withdrawal of comfort care from me.

My agent (or any successor agent) may authorize the withholding of life-sustaining treatment as set forth in my living will or advance directive (except for any limitations given therein) if I have executed one.

In the event I am unable to communicate verbally or nonverbally, demonstrate no purposeful movement or motor ability, and am unable to interact purposefully with environmental stimulation and (1) I have an incurable and irreversible condition such that, in accordance with accepted medical standards, death is imminent if life-sustaining treatment is not administered, or (2) I am in a coma or I have a condition of permanent unconsciousness that, in accordance with accepted medical standards, will last indefinitely without significant improvement: *(Initial only one of the following three options and if you do not agree with either of the first two options, space is provided below for you to write your own instructions.)*

_____ I authorize my agent (or any successor agent) to direct the withholding of artificial nutrition or hydration from me.

_____ I do not authorize my agent (or any successor agent) to direct the withholding of artificial nutrition or hydration from me.

_____ I authorize the following: _____

This durable power of attorney for health care is effective only during any period in which my physician has determined in good faith that I do not have decisional capacity.

Whenever making any health care decision for me, my agent (or any successor agent) shall consider the recommendation of my attending physician, the decision I would have made if I then had decisional capacity (if known) and the decision that would be in my best interests.

I give the following instructions to help guide my agent (or any successor agent): (*You may write additional instructions or limitations below.*)

_____

_____

_____

Date: _____, 2____ _____
(your signature)

_____ _____
(your address) (type or print your name), principal

Notarization

On this the ____ day of _____, 2____, the principal, _____, personally appeared before the undersigned officer and signed the foregoing document in my presence.

_____
Notary Public

[SEAL]
My commission expires:

OR

Statements of Two Witnesses

The principal voluntarily signed this document in my presence.

_____
(first witness signature)

_____ _____
(witness address) (type or print witness' name), witness

The principal voluntarily signed this document in my presence.

_____
(second witness signature)

_____ _____
(witness address) (type or print witness' name), witness

NOTICE TO PERSON MAKING A DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This is an important legal document. Prepare this durable power of attorney for health care carefully. If you use this form, read it completely. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes.

You have the right to revoke this document in whole or in part at any time you have not been determined to be incapable. A revocation is effective when it is communicated to your attending physician or other health care provider. This Form was made fillable by eForms.

SOUTH DAKOTA LIVING WILL DECLARATION

This is an important legal document. A living will directs the medical treatment you are to receive in the event you are in a terminal condition and are unable to participate in your own medical decisions. This living will may state what kind of treatment you want or do not want to receive.

Prepare this living will carefully. If you use this form, read it completely. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes.

This living will remains valid and in effect until and unless you revoke it. Review this living will periodically to make sure it continues to reflect your wishes. You may amend or revoke this living will at any time by notifying your physician and other health care providers. You should give copies of this living will to your family , your physician, and your health care facility. This form is entirely optional. If you choose to use this form, please note that the form provides signature lines for you, the two witnesses whom you have selected, and a notary public.

TO MY FAMILY, HEALTH CARE PROVIDER, AND ALL THOSE CONCERNED WITH MY CARE:

I, _____ direct you to follow my wishes for care if I am in a terminal condition, my death is imminent, and I am unable to communicate my decisions about my medical care.

With respect to any life-sustaining treatment, I direct the following:

(Initial only one of the following options. If you do not agree with either of the following options, space is provided below for you to write your own instructions.)

_____ If my death is imminent or I am permanently unconscious, I choose not to prolong my life. If life sustaining treatment has been started, stop it, but keep me comfortable and control my pain.

_____ Even if my death is imminent or I am permanently unconscious, I choose to prolong my life.

_____ I choose neither of the above options, and here are my instructions should I become terminally ill and my death is imminent or I am permanently unconscious:

_____

_____

_____

_____

_____

_____

_____

Artificial Nutrition and Hydration: food and water provided by means of a tube inserted into the stomach or intestine or needle into a vein.

With respect to artificial nutrition and hydration, I direct the following:

(Initial only one)

_____ If my death is imminent or I am permanently unconscious, I do not want artificial nutrition and hydration. If it has been started, stop it.

_____ Even if my death is imminent or I am permanently unconscious, I want artificial nutrition and hydration.

Date: _____

_____

(Your signature)

_____

(Type or print your signature)

_____

(Your address)

The declarant voluntarily signed this document in my presence.

Witness _____

(Signature)

_____

(Type or print signature)

Address _____

(Street) (City) (State)

Witness _____

(Signature)

_____

(Type or print signature)

Address _____

(Street) (City) (State)

On this the _____ day of _____, _____, the declarant, _____, and witnesses _____, and _____ personally appeared before the undersigned officer and signed the foregoing instrument in my presence. Dated this _____ day of _____, _____.

_____

Notary Public

My commission expires: _____

{Seal}

Source: SDCL 34-12D-3

Form made Fillable by eForms