General Instructions for Caregivers and Consent document

- **IMPORTANT**: Initial all portions that apply to the left of the item. Do not make a check mark or an "x". Use your initials to show you intentionally selected this item.

- Add anything you are allergic to, or medications or treatments that you don't want administered, in the blank lines in the fillable area. Don't forget to initial the blank lines area if you add information. If you do not add additional information in blank lines area, DO NOT initial the blank lines area or fill out any information.

- Notarize the document: **ONLY SIGN THIS CAREGIVERS AND CONSENT DOCUMENT AND LETTER BEFORE THE NOTARY.**

- Make at least 10 copies (for extras) and attach a copy of your Medical Power of Attorney to each copy.

1. Mail to the hospital the letter, a copy of this Caregivers and Consent document, and copy of your Medical Power of Attorney. Use a United States Postal Service *Priority Mailer* and Certified Mail with Return Receipt Requested. Address the *Priority Mailer* to the CEO at the hospital's physical address.

2. Courier Service a copy of the above letter, copy of this Caregivers and Consent document, and a copy of the Medical Power of Attorney to the CEO at the hospital's physical address.

3. Give a copy of this Caregivers and Consent document with an attached copy Medical Power of Attorney to the Attending Physician.

4. Give a copy of this Caregivers and Consent document with an attached copy Medical Power of Attorney to the Nurse.

5. Keep the additional copies of this Caregivers and Consent document with an attached copy of the Medical Power of Attorney for your records and to distribute, as needed, to other care providers.

6. Keep a copy of the letter, this Caregivers and Consent document, and Medical Power of Attorney with the Certified Mail number and Return Receipt Requested signature; keep the Courier Service receipt information.

7. Keep this original Caregivers and Consent document in a safe place.

8. Finally, feel free to use different wording or modify this for your own Directives for Care document if you so choose; the important takeaway is to clearly communicate in writing your consent, or lack thereof, to healthcare providers.

Caregivers and Consent

I am the Medical Power of Attorney for Patient named_____ with Date of Birth_____ and the following items in this Caregivers and Consent document apply. Please ensure that this Caregivers and Consent document is clearly accessible in the electronic medical records at all times for all care providers.

PLEASE BE ADVISED: (1) failure to comply with the items in this Caregivers and Consent document, and/or (2) failure to provide adequate informed consent, and/or (3) violation of patient rights shall result in a complaint to the Medical Board for the physician(s). Receipt of this Caregivers and Consent document by the hospital shall serve as notice.

_____**I DO NOT CONSENT TO THE USE OF MEDICATIONS WITHOUT BEING INFORMED OF EACH MEDICATION'S RISKS, BENEFITS, AND ALTERNATIVES BEFORE THEY ARE ORDERED FOR PATIENT NAMED _____ WITH DATE OF BIRTH_____.** Only after that information is communicated shall I choose, as Medical Power of Attorney for Patient named_____ with Date of Birth_____, to either grant consent or to not grant consent for each and every medication that is ordered.

_____**I DO NOT CONSENT** to Patient named_____ with Date of Birth_____ receiving any vaccine or booster for COVID19 or COVID19 variant.

_____**I DO NOT CONSENT** to Patient named_____ with Date of Birth_____ receiving the seasonal Flu vaccine.

_____**I DO NOT CONSENT** to Patient named_____ with Date of Birth_____ receiving the Pneumococcal vaccine.

_____**I DO NOT CONSENT** to Patient named_____ with Date of Birth_____ receiving **ANY** vaccination for **ANY** purpose or disease.

_____**I DO NOT CONSENT** to the use of Remdesivir, or its generic called Veklury, or any drug related to Remdesivir or Veklury under any circumstances for Patient named_____ with Date of Birth_____.

_____**I DO NOT CONSENT** to the use of Baricitinib, or its brand name Olumiant, for COVID19 or COVID 19 variant for Patient named_____ with Date of Birth_____.

_____**I REQUEST AND CONSENT** to the use of 1mg of Budesonide via nebulizer every 4 to 6 hours for Patient named_____ with Date of Birth_____, for COVID19 or COVID19 variant diagnosis with respiratory issues.

_____**I DO NOT CONSENT,** as Medical Power of Attorney for Patient named_____ with Date of Birth_____, to a ventilator in the case of a COVID19 or COVID19 variant diagnosis **WITHOUT** the physician's consultation with me

regarding the risks, benefits, and alternatives **PRIOR** to the implementation of the ventilator. Only **AFTER** that information is communicated shall I choose, as Medical Power of Attorney for Patient named_____ with Date of Birth_____, to either grant consent or to not grant consent for the ventilator in the case of a COVID19 or COVID19 variant diagnosis.

____**I DO NOT CONSENT** to medications related to any COVID19 protocol or COVID19 variant protocol for Patient named_____ with Date of Birth_____ **WITHOUT** my first conducting an independent evaluation, as Medical Power of Attorney, regarding side effects or risks associated with the COVID19 protocol or COVID19 variant protocol medications. Only I, as Medical Power of Attorney, may approve COVID19 Protocol medications or COVID19 variant protocol medications. *Under no circumstances should any COVID19 protocol medication or COVID19 variant protocol medication, or COVID19 treatment plan medication or COVID19 variant treatment plan medication, be given without my specific approval for each and every medication.*

_____In the event that new medications or treatment options for COVID19 or COVID19 variant are made available, as Medical Power of Attorney I will conduct an independent evaluation regarding the side effects or risks associated with any new medications or treatment options **PRIOR** to consenting to the administration of new medications or treatments for Patient named_____ with Date of Birth_____.

_____**I REQUEST AND CONSENT**, as Medical Power of Attorney, the implementation of alternative treatments for COVID19 and COVID19 variants (like those offered as alternative protocols including Ivermectin and Hydroxychloroquine) for Patient named_____ with Date of Birth_____. If the facility does not allow for the use of any alternative medical treatments for COVID19 or COVID19 variant**, I CONSENT AND DIRECT**, as Medical Power of Attorney, that Patient named_____ with Date of Birth_____ be discharged to another facility.

_____**I REQUEST AND CONSENT** to the use all life-saving measures for Patient named_____ with Date of Birth_____. In the event as Medical Power of Attorney I consent to hospice level of care, **I REQUEST AND CONSENT** that Patient named_____ with Date of Birth_____ be provided oxygen, nutrition, hydration, medication, and any other equipment necessary for comfort.

____I also **DO NOT CONSENT** to the following for Patient named_____ with Date of Birth_____:

_____

_____

_____

_____

All the items in this Caregivers and Consent document shall remain in effect unless I choose to revoke in writing; no one else may alter or amend this Caregivers and Consent document.

_____ _____ _____

Signature Initials Date:

NOTARIZED ACKNOWLEDGEMENT

State of:_____

County of:_____

PERSONALLY came and appeared before me, the undersigned Notary, within the

named _____, who is a resident of _____County, State of

_____.