GENERAL INSTRUCTIONS

General Instructions

- Initial all portions that apply
- Add any allergies or medications that you don’t want administered

DIRECTIVE TO PHYSICIANS AND MEDICAL POWER OF ATTORNEY OR SURROGATE REGARDING TREAMENTS, THERAPIES AND PROTOCOLS

I, ______________________________, recognize that the best health care is based upon a partnership of trust and communication and shared decision making with my physician. My physician and I will make health care or treatment decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored as my carefully planned and intentional wishes:

_____**I DO NOT CONSENT** to the use of Remdesivir under any circumstances.

_____**I DO NOT CONSENT** to receiving any vaccine or booster for COVID19.

_____**I DO NOT CONSENT** to receiving the seasonal Flu vaccine.

_____**I DO NOT CONSENT** to receiving the Pneumococcal vaccine.

_____**I DO NOT CONSENT** to ventilator in the case of a COVID19 diagnosis.

____**I DO NOT CONSENT** to COVID19 medications related to any COVID19 Protocol without my Medical Power of Attorney or Surrogate first conducting an independent evaluation regarding side effects or risks associated with the COVID 19 Protocol medications. Only my Medical Power of Attorney or Surrogate may approve COVID19 Protocol medications. *Under no circumstances should any COVID19 Protocol medication or COVID19 treatment plan medication be administered without my Medical Power of Attorney's or Surrogate's specific approval for each and every medication to be administered.*

____**I ALSO DO NOT CONSENT TO**: ____

____.

______If the facility does not allow for the use of any alternative medical treatments for COVID19**,** I direct my Medical Power of Attorney or Surrogate to have me discharged to another facility or level of care. If I am discharged to a hospice level of care, I direct that I be provided oxygen, medication, and any other equipment necessary for my comfort.

______ In the event that new medications or treatment options for COVID19 are made available. I direct my Medical Power of Attorney or Surrogate to 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.

____I specifically direct my Medical Power of Attorney or Surrogate to seek alternative treatments for COVID19 (like those offered as alternative protocols including Ivermectin and Hydroxychloroquine).

This directive will remain in effect until I revoke it. No other person may do so.

____________________________ _________ _______________________

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 ________________.