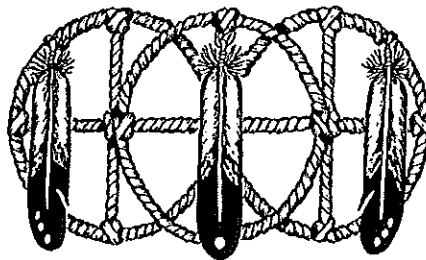


**YELLOWHAWK**  
TRIBAL HEALTH CENTER  
P.O. Box 160  
Pendleton, Oregon 97801  
(541) 966-9830



**Consent For Medical or Dental Care**  
I, the undersigned, the natural parent/legal guardian of

\_\_\_\_\_

(Name of Patient/child)

hereby authorize and give my full permission to the following person(s)

\_\_\_\_\_

(Name of Person)

\_\_\_\_\_

(Name of Person)

\_\_\_\_\_

(Name of Person)

To act in my behalf to consent to any:

Medical \_\_\_\_\_ Dental \_\_\_\_\_ Mental Health/Social Services \_\_\_\_\_

Care deemed necessary to be rendered to my child under the general or special supervision and upon advice of the physician or dentist at the Yellowhawk Tribal Health Center.

\_\_\_\_\_

(Date)

\_\_\_\_\_

(Name/Relationship to patient/child)

\_\_\_\_\_

(Address)

**This form expires 1 year from date signed**