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