CONSENT FOR TREATMENT OF MINOR CHILD

Child's Name ______________________ Date of Birth ______________________

Parent/Legal Guardian ______________________ Phone Number ______________________

Relationship to the Minor Child ______________________

Parent/Legal Guardian ______________________ Phone Number ______________________

Relationship to the Minor Child ______________________

Authorized Caregiver's Information:

Caregiver's Name ______________ Relationship to Child ______________ Phone Number ______________

Caregiver's Name ______________ Relationship to Child ______________ Phone Number ______________

The above named caregiver shall be authorized to consent for all medical and/or dental treatment, for the above named child, which may be required during my absence. I agree to pay for all services provided to my child that the caregiver authorized. If circumstances permit and/or Kaniksu Community Health needs to contact me, please contact me at the following phone number: ______________________________

This consent serves as permission for treatment by Kaniksu Community Health, for the above named child. This authorization shall remain in effect for one year from the signing date, unless otherwise revoked in writing and submitted to Kaniksu Community Health prior to the expiration date.

Signature of Patient Parent or Guardian ______________ Date ______________ Provider's Signature ______________

Note: Consents are not required in emergency situations.

Providing our communities with quality, affordable & accessible healthcare

Bonners Ferry	Ponderay	Priest River	Sandpoint Pediatrics	VA	Administration
6615 Comanche Street	30410 Hwy. 200	6509 Hwy. 2	420 N. 2nd Ave.	420 N. 2nd Ave.	301 Cedar St. Suite 206
Bonners Ferry, ID	Ponderay, ID	Priest River, ID	Sandpoint, ID	Sandpoint, ID	Sandpoint, ID
83805	83852	83856	83864	83864	83864
208.267.1718	208.265.6252	208.448.2321	208.265.2242	208.263.0450	208.263.7101