Authorization to Consent to Treatment of Minor

When Parents or Legal Guardian are Unavailable the undersigned hereby authorizes the Band Director or his representative to give consent to medical or surgical treatment by any licensed physician or hospital in the states of Washington, Oregon and Idaho, and the province of British Columbia, Canada for our child, ____________________________ (Date of birth ____/____/____), when such treatment is deemed necessary by such physician and we cannot be reached within a reasonable time, by reason of absence from the community or otherwise.

Such consent may include, but is not limited to, administration of necessary anesthetics, medical treatment, tests, X-ray examinations, transfusions, injections, or drugs and the performing of whatever operations may be deemed necessary or advisable. Further, consent is granted to said physician to exercise his/her discretion in authorizing the disposal of any severed tissue or members.

It is understood this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide the authority to consent thereto, as our said agent and my child's attending physician, in the exercise of the their best judgment, may deem advisable.
This authorization shall remain effective until _______________ unless sooner revoked in writing by the undersigned.

PLEASE COMPLETE:
Does your child have a physician who should be contacted?

Yes No. If so, whom? ____

Physican's Phone___________________________________

Date of last tetanus immunization: ___________________________

Does your child have any chronic diseases? Yes No. If so, please name: _______________________________

Does your child have any drug allergies? Yes No. If so, to what drugs? ________________________________

____
Parent/Guardian Signature

____
Home Address

____
Home Phone

____
Insurance Company

____
Policy Number

____
Date

____
Work Phone