GLACIER COMMUNITY HEALTH CENTER / GLACIER DENTAL CLINIC

Authorization to Consent to Routine and Emergency Treatment of My Minor Child

Child's Name_____ **DOB:**_____

Mother's Name:_____ **Father's Name:** _____

____I give my child permission to schedule his/her own appointment.
- ____Medical
- ____Mental Health
- ____Dental

____I do not give permission for my child to schedule his/her own appointment.

____I give permission for my child to come alone for routine care.
Phone # at which I can be reached during appt: _____

____Child does not have permission to come alone.

PROXY DECISION MAKER

I hereby authorize and grant permission to the following persons ("Proxy Decision Makers") to make decisions about and consent to the provision of routine care and acute treatment by Glacier Community Health Center to my minor child.

The following person(s) are allowed to make basic decisions about routine and acute treatment by Glacier CHC for my child:

Name	Address	Phone	Relationship to Child	Access to Medical Record
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N

The Proxy Decision Maker shall only be acknowledged and accepted by Glacier Community Health Center upon production of appropriate photo identification, such as a driver's license.

I hereby fully and irrevocably release and discharge Glacier Community Health Center from liability for all appropriate medical care provided to my minor child based upon reliance on this Authorization.

I understand that I may revoke this Authorization, in writing, at any time.

CONTACT INFORMATION

If the nature of the medical, mental health, or dental care to be provided to my child is *not routine or acute care but is emergent and requires immediate medical attention*, please provide such care and then contact me regarding the emergent treatment at the following telephone numbers. If I am unable to be reached, Glacier Community Health Center may rely on the person(s) noted above to consent to all care for my minor child.

Parent's Name:_____

Phone: _____(daytime)_____(evening) _____(cell)

IN WITNESS WHEREOF, the undersigned has executed this Authorization as of _____.
(date)

_____
Signature of Parent or Legal Guardian of Minor

GLACIER
Community Health Center

To: All Parents or Guardians of our pediatric patients

Re: Pediatric Patient Consent

In most cases, a parent or guardian must consent to medical treatment for minors in the State of Montana. Sometimes other family members or friends bring children to our center for care. We need, however, to insure your consent before we can administer care to your child.

A proxy is an adult that fills in for you if you cannot come yourself. If you want another adult to serve as proxy and bring your child in for medical, mental health, or dental care, you must let us know by filling out and signing our consent form. When you fill out this form, you are telling us who you trust to bring your child in for medical care.

Please take a few moments to fill out the form and hand it back to the front desk staff or nurse. We will scan it in your child's chart.

We can no longer see children without the appropriate adult except to treat medical emergencies.