Karen I. Fryberg Tulalip Health Clinic
PRE-CONSENT FORM FOR TREATMENT OF MINOR

I, the parent/legal guardian of ______________________________ born ____________
(Name) (Date of Birth)

do hereby empower and grant ______________________________ at ____________
(Name) (Phone Number)

______________________________ at ____________
(Name) (Phone Number)

______________________________ at ____________
(Name) (Phone Number)

the permission to consent to and authorize:

- ☐ immunizations
- ☐ non-emergent medical care and treatment
- ☐ non-invasive dental treatment

for my above-named child/ward in lieu of my absence.

This authorization shall be valid for the period commencing on ____________ (Month / Day / Year) and ending ____________ (Month / Day / Year), a period not longer than 6 months. In consideration of my absence during my child's/ward's medical and/or dental care, I do hereby indemnify and hold harmless the physicians, clinic, and other persons who act in reliance upon this authorization.

Executed this __________ day of ______________________________, 20___.

______________________________	______________________________
Parent Name, printed	Parent Signature
______________________________	______________________________
Guardian Name, printed	Guardian Signature

Parent/Legal Guardian Contact Information:

Phone: ______________________________ ☐ Home ☐ Cell ☐ Work ☐ Neighbor /Relative

Alternate Phone: ______________________________ ☐ Home ☐ Cell ☐ Work ☐ Neighbor /Relative

Address: ______________________________ ☐ Permanent Home ☐ Transition Home ☐ Work

____

____

I attest that I have attached a copy the following proof of parent's/guardian's identity and signature:

☐ Driver's License ☐ WA State ID ☐ Other photo ID ☐ Other documentation

______________________________	______________________________	________
THC Staff Witness Name, printed	THC Staff Witness Signature	Date