HO-CHUNK NATION
DEPARTMENT OF HEALTH

I, __________________ parent/guardian of __________________, Date of Birth __________, give my permission for him/her to be treated at one of the Ho-Chunk Nation Health Care Facilities under the following conditions:

__ Unaccompanied/without my presence (certain visits may require parent/guardian to be present) ***NOTE Child must be at least 16 years of age.**

__ Accompanied by ____________________Relation________________ (acting on my behalf)

For:

__ Only for the following date(s): _______________________________

__ All future appointments **(from 1 year of today's date).**

__ Immunizations/Injections

__ Evaluation & Treatment which may include lab testing, prescriptions, etc.

I understand that immunizations, certain injections, require an additional consent form to be signed at the time of the appointment.

I understand that this permission form will **expire 1 year from today's date**.

I can be reached at the following telephone number(s) for the provider to inform me of my child's condition: ____.

_____________________________ ________________
Signature of Parent/Guardian Date

*Verbal Consent obtained from__________________by/date ____________________________

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