HO-CHUNK NATION
DEPARTMENT OF HEALTH

I, __________________ parent/guardian of __________________, Date of Birth __________, give my permission for them to be treated at one of the Ho-Chunk Nation Health Care Facilities accompanied by ____________________ (must be at least 18 years old) for

__ Any appropriate immunizations/vaccines **ONLY**.

__ Any indicated medical, dental, or other care (possibly including lab testing, prescriptions, etc). Person accompanying minor must be knowledgeable about minor's health. Health screening forms for well child visits should be filled out by parents prior to appointment.

My child has the following health needs:

Allergies (if none, write "None"):____

____

Conditions (if none, write "None"): ____

____

Medications (if none, write "None"):____

____

I understand that immunizations, medical procedures, and dental procedures require an additional consent form signed at the appointment. I give the Ho-Chunk Nation providers permission to perform diagnostic, treatment, and preventative services based on: national recommendations, specialist recommendations, exams, testing results, and previous diagnoses.

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 ____________________________

*Rev. 08.01.23

Cc Patient Services & scan into "Legal" category.

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