Consent for
Medical/Emergency Treatment
and Child's Medical Information

In presenting my son/daughter for diagnosis and treatment

Name:_____ for _____ dob:_____
□ Mother □ Father □ Guardian □ Son □ Daughter

Of _____ years of age, hearby voluntarily consent to the rendering of such care, including diagnostic procedures and medical treatment, by authorized members of the Kewa Pueblo Health Corporation or their designees, as may in their professional judgement be necessary.

I hearby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment of my child's condition.

I have read this form and certify that I understand its contents.

We/I hereby give our (my) consent to _____
(Name of Person)
who will be caring for our (my) child _____
(Name of Child)

for the period _____ and/or _____ to arrange for routine or emergency medical/dental care and treatment necessary to preserve the health of our (my) child.

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period.

Name: _____

Address: _____

_____

Telephone No: _____

Name of health insurance carrier: _____

_____

_____

Group No: _____

Agreement No: _____

Family Physician: _____

Pediatrician: _____

Child's allergies, if any: _____

_____

Date of last tetanus booster: _____

Medicines child is taking: _____

_____

Signature: _____ Date: _____
Mother, Father or Legal Guardian

Witness: _____ Date: _____

In Case of Emergency, I can be reached at: _____