Kewa Pueblo Health Corporation

P.O. BOX 340 85 W. HIGHWAY 22
SANTO DOMINGO PUEBLO, NEW MEXICO 87052
TELEPHONE (505) 465-3060 FAX (505) 465-1178

Proxy Consent and Medical Treatment of a Minor Form

This form gives authorization for a non-parent/non-guardian to accompany your **minor patient to appointments and to authorize care during appointments/walk-in visits.**

Minor Patient Information

Medical Record #: _____

First Name _____ Middle _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Phone number _____

In case of an emergency, I can be contacted at: ( ) _____

Medical History:

Child's allergies, if any _____

Allergies to any medications _____

Medicine child is currently taking _____

YES ☐ NO ☐
Is the child up date with vaccination/immunizations

The Right to Revoke This Minor Consent Form: As the parent/legal guardian of the patient listed above, you have the right to revoke this consent form at any time by giving written notice to Santo Domingo Health Clinic or by completing a new Minor Consent Form authorizing new non-parent/non-guardian to accompany your minor child on their next appointments. Please contact **Santo Domingo Health Clinic** at **(505) 465-3060** for more information if you desire to cancel or update a new authorization.

Proxy Consent Form for Minors

1. I authorize the person(s) named on this form to accompany/make decisions regarding the following health services for my child:
   a. Regular health care, including but not limited to medical examinations, routine laboratory studies, immunizations, and physical therapy evaluation and treatment.
   b. Dental care, including but not limited to, dental hygiene visits, necessary emergency dental care.

(Initials) _____ **Dental Expectations:** Parent or Guardian **MUST** be present for **dental examinations** and **extractions**.

   c. Eye related services including eye examinations and treatments.
   d. Emergency health care for accidents or illness.
   e. Behavioral Health/counseling related services.
2. The person(s) named on this form has/have agreed to accompany and make decisions regarding the health services listed above.
3. I understand my authorization will remain in effect for the length of the time specified below:

Expiration date (not to exceed one year; form must be completed yearly):

From: _____ **End:** _____
Beginning Date **End Date**

NOTE:

- A parent or legal guardian must attend a **minor's first visit** at Santo Domingo Health Center.
- A parent or legal guardian must provide this form directly to patient registration staff in person before the minor's appointment date. If you are unable to present this form in person, you must fax the form along with a copy of your government **ID or Driver's license** to the Medical Records fax number **(505) 465-1178.**
- The "Proxy Consent and Medical Treatment of a Minor Form" without a parent or legal guardian present is only effective for the time frame listed on this form. **Incomplete form will not be a valid authorization.**
- In certain circumstances, in accordance with State and Federal laws, parent or legal guardian permission may not be needed for adolescents being treated for concerns deemed as "heightened sensitivity", including but not limited to STD testing, family planning, mental health, etc.

Authorized non-parent/non-guardian representative information:

1.

First Name _____ Middle _____ Last Name _____

( ) _____ Home Phone Number

( ) _____ Alternative Phone

_____ Relationship to Minor

_____ Date of Birth

2.

First Name _____ Middle _____ Last Name _____

( ) _____ Home Phone Number

( ) _____ Alternative Phone

_____ Relationship to Minor

_____ Date of Birth

I, _____, having had full opportunity to read and consider the content of this
(parent/guardian name printed)
authorization form, confirm my agreement for the above-named person(s) to accompany my minor child as named on this form.

Parent/Legal Guardian Signature _____ **Relationship to Minor** _____

Date: _____

Parent/Legal Guardian ID

---------- OFFICE USE ONLY ----------

Phone Verbal Consent

(One Day Verbal Consent ONLY)

SDHC Patient Registration Signature and Name: _____ **Date** _____ **Time:** _____

SDHC OPD Witness Signature and Name: _____ **Date:** _____ **Time:** _____

Consent given by:

☐ Mom: _____ DOB: _____

☐ Dad: _____ DOB: _____

☐ Legal Guardian: _____ DOB: _____

Phone #: _____

(Yearly)