Siletz Community Health Clinic

Consent for Alternate person to bring Minor Child to Appointments

__________ Initials

I understand that I, parent/guardian, must bring my child to the first appointment or any pre surgery clearance appointment with a SCHC provider, in order to give a complete medical history. Following the first visit, I acknowledge that by listing the following people, I hereby authorize and give my permission to act in my behalf to consent and seek care deemed necessary by the SCHC provider.

Alternate individual(s) that may bring child to SCHC for treatment at any department they have an appointment, unless department policy requires legal guardian present.

Name (full legal name)	Nickname	Relationship

Attestation

By signing below, I attest I have received, reviewed, and understand the information above. If I choose to revoke or change this form, it must be done in writing.

______________________________ _______________
Patient Name *(please print)* Date of Birth

______________________________ _______________
Patient Signature *(or Parent/Patient Representative)* Today's date

______________________________ _______________
Name of Parent/Patient Representative