MINOR OR DISABLED ADULT CONSENT FORM

I, _____, parent, legal sponsor, or legal guardian of _____ hereby give permission for the Ponca Tribe of Nebraska Health Services Department ("Department") to evaluate, examine, diagnose, and treat my child in the event that I cannot be contacted through reasonable efforts or am unable or choose not to attend an appointment for my child. I hereby empower and grant either:

_____ Relationship: _____, OR

_____ Relationship: _____

permission and responsibility to (1) present or update pertinent information about my above child's medical and dental history, medication list, and medication allergies; (2) consent to and authorize medical, dental, and hospital care, treatment and procedures (including the administration of anesthesia) for my above child; and (3) receive and be given pertinent information about my above child's illness or condition. I understand that it is my responsibility to ensure that the above individual(s) have accurate information and knowledge about my child and will provide such information to them as necessary.

I declare under penalty of perjury that I have the authority to give this permission for my above child and the authority to make decisions about the medical and dental care of my above child.

I understand that the treating physician, dentist, or other health care personnel reserves the right to require me, as parent, legal sponsor, or legal guardian, to be present during any particular procedure or appointment if the treating health care personnel deems it necessary for the procedure or appointment. I also understand that the Department requires that the above individual(s) accompanying my child must remain in the waiting room for the duration of the appointment.

I do hereby indemnify and hold harmless the Ponca Tribe of Nebraska, Department, and their clinics, physicians, staff, and other persons who act in reliance upon this authorization.

Expiration (check one):

- ☐ This consent will expire SIX (6) months from the date of execution.
- ☐ This consent is VALID ONLY from ____/____/_____ to ____/____/_____.
- ☐ This form will remain in effect until revoked by me in writing.

I may revoke this consent or add or delete a name any time by notifying the Medical Records/Patient Registration staff in writing.

Physical signatures only. Please email form to poncadental@poncatribe-ne.gov or bring into your appointment.

_____ Date: _____
Signature

_____
Relationship to Patient

_____ Date: _____
Witness

_____
Print Name