KODIAK AREA NATIVE ASSOCIATION

HEALTH SERVICES

CONSENT FOR TREATMENT OF MINOR

Minor Patient Name: _____ Date of Birth: _____

Name(s) of All Parent(s) and/or Legal Guardian(s) With Authority to Consent to Medical Treatment for Minor Patient: _____

Name of Parent or Legal Guardian Filling Out This Form: _____
Relationship to Minor: _____
If Sharing Custody of Minor with Other Parent – Do you have LEGAL custody of the minor? (Y/N) _____
Phone #: _____

By completing and signing this form, I hereby consent to the medical or dental treatment of the above named minor, and represent that I have the legal authority to do so as the minor's parent or legal guardian, with the understanding that KANA may ask me to provide written proof of such authority. I further consent to KANA's treatment of the above-named minor in the following circumstances:

☐ ***Emergency Care:*** I authorize KANA and its healthcare personnel to provide emergency medical care to the above-named minor, as determined in their professional judgment to be necessary to preserve the minor's life, safety, and well-being, where it is not feasible or practical to contact me (or another parent or legal guardian) before providing such care. I understand that KANA will nonetheless attempt to contact me (or another parent or legal guardian) as soon as possible, without causing delay to the minor's emergency treatment or care.

☐ ***Non-Emergency Care:*** I authorize KANA and its healthcare personnel, including dental, to provide routine medical care for minor injuries or illnesses to the above-named minor, as determined in their professional judgment to be advisable to the minor's treatment, care and well-being, in circumstances where the minor is not accompanied by me (or another parent or legal guardian), and KANA is not able to reach me (or another parent or legal guardian).

☐ ***Non-Emergency Care Where Accompanied by Adult:*** I authorize KANA and its health care personnel, including dental, to provide routine medical care to the above-named minor, as determined in their professional judgment to be advisable to the minor's treatment, care and well-being, where the minor is not accompanied by me (or another parent or legal guardian) but is accompanied by one of the following individuals:

Name: _____ Relationship to Minor: _____
Name: _____ Relationship to Minor: _____
Name: _____ Relationship to Minor: _____

This consent form will expire one (1) year from the date of signature below, unless I indicate that it should expire on the following date or event: _____

I understand that under Alaska law, A.S. 25.20.025, minor patients have the right to consent to their own medical care in the following circumstances:

- The minor is living apart from the minor's parents or legal guardian and is managing the minor's own financial affairs, regardless of the source or extent of income;
- The parent or legal guardian of the minor cannot be contacted or, if contacted, is unwilling either to grant or withhold consent;
- The minor is seeking diagnosis, prevent, or treatment of a pregnancy;
- The minor is seeking diagnosis or treatment of a sexually transmitted infection/disease; or
- The minor is a parent of a child and may give consent to medical and dental services for the minor child.

I further understand that where a minor seeks care on his/her own behalf, I generally do not have a right of access to information relating to such care.

By signing this consent form, I represent to KANA that I have the legal authority to make decisions relating to the medical care of the minor patient.

Signature	**Date**

Verbal consent requires two witnesses

Witness	**Date**
Witness	**Date**

For KANA's Use Only

Intake By: _____ Chart #: _____

Date: _____