Chico Clinic
845 W. East Avenue
Chico, CA 95926
(530) 896-9400
Fax: (530) 896-9407

Dental and Maternal Health Center
500 Cohasset Rd. Ste 15
Chico, CA 95926
(530) 433-2500
Fax: (530) 433-2511

Children's Health Center
277 Cohasset Road
Chico, CA 95926
(530) 781-1440
Fax: (530) 342-1663

Red Bluff Clinic
2500 N. Main Street
Red Bluff, CA 96080
(530) 529-2567
Fax: (530) 529-2552

Willows Clinic
207 N. Butte Street
Willows, CA 95988
(530) 934-4641
Fax: (530) 934-4081

Woodland Clinic
175 West Court Street
Woodland, CA 95695
(530) 661-4400
Fax: (530) 661-4416

Mobile Dental Clinic
530-520-6913
www.nvih.org

Northern Valley Indian Health, Inc.

Permission to Treat a Medical Minor without a Parent or Guardian Present

Northern Valley Indian Health, Inc. (NVIH) must receive permission from a minor's parent or legal guardian before providing treatments for a medical appointment that is non-life threatening (consent to treat is generally implied in emergency situations). This form gives us legal permission to treat your child in case you cannot accompany him/her to NVIH for a medical treatment for a follow-up medical appointment or a non-invasive medical treatment with the exception of vaccines. NVIH will treat your minor child without you present for a medical visit provided all the following conditions are satisfied:

- A parent or legal guardian must attend any initial evaluation or visit for a minor at NVIH.
- The minor child is twelve (12) years old or older.
- A parent or legal guardian must provide this form directly to our office, in person, before the effective date of this form.
- The parent or legal guardian has informed our office that they will not be present during the appointment before the minor comes in for their appointment.
- This "Permission to Treat a Minor without a Parent or Guardian Present" is only effective for the time frame listed below.
- The medical provider reserves the right to refuse to treat minors for non-life threatening care if he/she deems it necessary to have the parent/legal guardian present during such care.

Patient's Name: _____ Patient's Date of Birth: _____

In case of an emergency, I can be reached at:

Name: _____

Address: _____

Home Phone Number: _____

Work Phone Number: _____

Other Contact Phone Number: _____

AUTHORIZATION

I, _____, the parent/legal guardian, of _____ have the legal right to preauthorize NVIH and its personnel to deliver medical treatment and services to my minor child named above. I hereby grant consent for my minor child to seek non-invasive medical treatment with the exception of vaccinations at NVIH unaccompanied by an adult.

From _____ (enter date) To _____ (enter date)

I acknowledge and agree that as the parent or legal guardian, I am responsible for all reasonable charges in connection with the care and treatment rendered for my minor child.

☐ I, the Patient/Legally Authorized Person, am able to communicate effectively in English.

Signature of Parent/Legal Guardian: _____ Date: _____

HRN# _____