OMB Control # 1076-0164 Expiration date: XX/XX/XXXX

## **AUTHORIZATION FOR MEDICAL CARE OF A MINOR**

This form for Authorization for Medical Care of a Minor gives permission for a physician, surgeon or dentist to provide necessary care to a child whose parents are not immediately available. School administration and staff, of course, will make every effort possible to contact you in case of an emergency.

Please fill out either <u>A or B:</u>	
A. I <u>DO CONSENT</u> AND AUTHORIZE	navioral or mental health care for cal or dental diagnosis and/or
In giving this consent, I recognize if it is not possible to contact me in these situation requires immediate medical, hospital, behavioral or mental health care, I authorized exercise their professional judgment and assess risks incident to and choose the neprofessional judgment determines to be necessary for the health or safety of the bright to opt-out of any non-emergency services.	e a physician, surgeon or dentist to ecessary treatment as their
Minor	
Full Legal Name:	_
Home Address:	_
Date of Birth:	
Parent / Legal Guardian	
Parent / Legal Guardian Printed Name:	
Parent I Legal Guardian Signature:	Date:
Home Address:	
Work Phone Number: Home Phone Number:	
B. I <u>DO NOT CONSENT</u> TO NOR AUTHORIZE the below named minor to receive no	on-emergency health care.
Minor	
Full Legal Name:	_
Home Address:	_ Date of Birth:
Parent / Legal Guardian	
Parent / Legal Guardian Printed Name:	
Parent I Legal Guardian Signature:	

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## **Paperwork Reduction Act and Public Burden Statement:**

Authority: Paperwork Reduction Act of 1995, Public Law 96-511, as amended.

This information is collected from Native American and Alaska Native parents and legal guardians seeking to authorize or decline to authorize medical care for a minor student enrolled in a Bureau of Indian Education-funded school. The information is used to identify students and their parents or legal guardians and to determine whether medical care of a minor student is authorized. The completed form is submitted to the school and kept on file to identify and maintain current information on students. It is estimated that this form will take an average of 15 minutes to complete. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB Control Number. Comments concerning clarity, utility of information or burden reduction may be sent to Attn: Information Collection Clearance Officer – Indian Affairs, 1849 C Street, NW, MS-3601, Washington, DC 20240. Please note: comments, names, and addresses of commentators are available for public review during regular business hours. If you wish us to withhold this information you must state this prominently at the beginning of your comment. We will honor your request to the extent allowable by law.

## PRIVACY ACT STATEMENT

**Authority:** 25 CFR 36.97 (c). **Purpose:** The principal purpose for collecting the information is to document authorization / non-authorization of medical care for a child whose parents are not immediately available. **Routine Uses:** This form for Authorization for Medical Care of a Minor gives permission for a physician, surgeon or dentist to provide necessary care to a child whose parents are not immediately available. Disclosure is subject to published routine uses identified in the Privacy Act System of Records Notice: BIA-22, Native American Student Information System. **Disclosure:** Voluntary; however, failure to provide requested information may result in inaccurate identification of minor, inability to determine if medical care is authorized, and inability to notify parent/legal guardian in cases of emergency.