NOLI INDIAN SCHOOL

SOBOBA BAND OF LUISEÑO INDIANS

CLEARANCE PACKET

All items in this packet must be completed and turned into the athletic office before an athlete will be cleared for participation in any sport at Noli Indian School.

PARENT AUTHORIZATION

The student named below has permission (and I am the legal guardian) to participate in athletics at Noli Indian School and to be transported and supervised by authorized persons throughout the school year. Stated in California Education Code Section 35330. I understand that I hold the Noli Indian School System; its officers, agents and employees harmless from any liability or claims, which may arise out of or in connection with my child's participation in athletic events.

_____ _____

Signature of Parent/Legal Guardian Date

PERSONAL INFORMATION

Students Name: _____ Home Phone #: _____

Grade Level: _____ Age: _____ Date of Birth: _____

Home Address: _____

Mailing Address: _____

Mother/Guardian Name & Work Number: _____

Father/Guardian Name & Work Number: _____

PARENT PERMISSION AND EMERGENCY AUTHORIZATION

Please list the name and phone number(s) of the parent or guardian to be notified in an emergency situation.

Parent/Guardian: _____ Home Phone #: _____

Business #: _____ Cell #: _____ _____

Family Physician: _____ Phone #: _____

I do hereby authorize and consent to any x-ray, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisably by and is rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that effort shall be made to contact the above named individual prior to rendering treatment to the patient, but that any of the above.

Treatment will not be withheld if the above named individual cannot be reached. The legal guardian assumes the financial burden for any such procedure. ***Noli Indian School***, its employees or agents. or volunteers will not be responsible for such cost

This authorization is given pursuant to the provision of section 25.8 of the Civil code of California

List any restriction(s): _____

_____ _____

Signature of Parent/Legal Guardian Date

I have read and I understand the athletic Code of Conduct for Noli Indian School. I accept the responsibilities of monitoring the actions of the student athlete whose signature appears above and I will do all I can to ensure that he/she complies with each item of the Athletic Code of Conduct as presently stated or subsequently amended.

_____ _____

Signature of Parent/Legal Guardian Date

Below Check Sport of Choice:

☐ Football	☐ Boys Basketball	☐ Softball	☐ Flag Football	☐ Girls Basketball
☐ Baseball	☐ Volleyball	☐ Track	☐ Cross Country	☐ Golf

10932 Pine Street
Los Alamitos, California 90720

Code of Ethics – Athletes

DO NOT SEND TO CIF SOUTHERN SECTION
A copy of this form must be kept on file in the athletic director's office at the local high school.

Athletics is an integral part of the school's total educational program. All school activities, curricular and extra-curricular, in the classroom and on the playing field, must be congruent with the school's stated goals and objectives established for the intellectual, physical, social and moral development of its students. It is within this context that the following Code of Ethics is presented.

As an athlete, I understand that it is my responsibility to:

1. Place academic achievement as the highest priority.
2. Show respect for teammates, opponents, officials and coaches.
3. Respect the integrity and judgment of game officials.
4. Exhibit fair play, sportsmanship and proper conduct on and off the playing field.
5. Maintain a high level of safety awareness.
6. Refrain from the use of profanity, vulgarity and other offensive language and gestures.
7. Adhere to the established rules and standards of the game to be played.
8. Respect all equipment and use it safely and appropriately.
9. Refrain from the use of alcohol, tobacco, illegal and non-prescriptive drugs, anabolic steroids or any substance to increase physical development or performance that is not approved by the United States Food and Drug Administration, Surgeon General of the United States or American Medical Association.
10. Know and follow all state, section and school athletic rules and regulations as they pertain to eligibility and sports participation.
11. Win with character, lose with dignity.

As a condition of membership in the CIF, all schools shall adopt policies prohibiting the use and abuse of androgenic/anabolic steroids. All member schools shall have participating students and their parents, legal guardian/caregiver agree that the athlete will not use steroids without the written prescription of a fully licensed physician (as recognized by the AMA) to treat a medical condition (Article 503.I).

By signing below, both the participating student athlete and the parents, legal guardian/caregiver hereby agree that the student shall not use androgenic/anabolic steroids without the written prescription of a fully licensed physician (as recognized by the AMA) to treat a medical condition. We recognize that under CIF Bylaw 202, there could be penalties for false or fraudulent information. We also understand that the Noli Indian School (school/school district name) policy regarding the use of illegal drugs will be enforced for any violations of these rules.

Printed Name of Student Athlete

Signature of Student Athlete Date

Signature of Parent/Caregiver Date

Revised 6/17

NOLI INDIAN SCHOOL

SOBOBA BAND OF LUISEÑO INDIANS

CO-CIRRUCULAR ACTIVITY CERTIFICATE FOR SCHOOL YEAR 20___ / 20___

(Insurance, Indemnification, Medical Authorization)

Pupil's Last Name First Name Middle Initial

School Attended Last Year: _____ City: _____

CHECK SPORTS YOU WILL BE PARTICIPATIONG IN:

☐ Baseball	☐ V. Basketball (Boys)	☐ V. Basketball (Girls)
☐ V. Football	☐ V. Softball	☐ V. Volleyball
☐ Cross Country	☐ Track	☐ Golf
☐ M.S. Basketball (Boys)	☐ M.S. Basketball (Girls)	☐ Flag Football
☐ M.S. Volleyball (Girls)	☐ M.S. Volleyball (Boys)	☐ M.S. Softball

The form must be on file with the school of attendance for verification of eligibility prior to participation in any co-curricular activity.

Note: The California Education Code requires that every student have $1,500 accidental medical insurance in order to participate in athletics or any other extra-curricular activity. (Ed. Code 32220-24)

SECTION I: (IF YOU HAVE YOUR OWN INSURANCE COVERAGE, PLEASE COMPLETE THIS SECTION) My medical coverage is for at least $l,500 and is issued by:

_____ _____

Name of Insurance Policy Policy Number

I further assure that the insurance policy or policies I hereby verify will remain current and in force during the time the above named student performs any function within the scope of Education Code Section 32220-24 and 35330-31 during the current school year of 20___ / _____.

_____ _____

Signature of Parent/Legal Guardian Date

INDEMNIFICATION

1 agree to indemnify and hold the Soboba Band of Luiseño Indians harmless against responsibility for insurance coverage required under the Education Code Sections 32220-24, 35330-31. By signing this statement. I agree to accept responsibility for all medical costs incurred by the above named pupil while participating in any school co-curricular program.

Your attention is directed to the fact that many insurance policies exclude tackle football. Please check your policy carefully or consult your carrier.

_____ _____

Signature of Parent/Legal Guardian Date

NOLI INDIAN SCHOOL

SOBOBA BAND OF LUISEÑO INDIANS

SECTION II

MEDICAL AUTHORIZATION

TO WHOM IT MAY CONCERN:

I, the undersigned, being the legal guardian of _____ do hereby grant to any hospital, emergency center, doctor, nurse, and or paramedic authorization to grant treatment to my child when accompanied by or escorted to the treating facility by a teacher, coach, teacher's aid, principal or any school designee.

Further, should the attending physician determine after examination that life saving surgery or other life-saving procedure may be necessary; permission is hereby extended to the above parties to grant same.

By my action of granting said permission, I agree to hold harmless school personnel, school designee, the Soboba Band of Luiseño Indians, and Noli Indian school.

I declare under penalty of perjury that the above is true and correct.

_____ _____

Signature of Parent/Legal Guardian Date

Home #: _____ Business #: _____ Cell #: _____

Emergency Contact Person: _____ Phone #: _____

Alternate Emergency Contact: _____ Phone #: _____

RESIDENCY

Athlete's Name: _____ Parent/Guardian Name: _____

Address: _____

City: _____ Zip: _____ Phone #: _____

I HEREBY CERTIFY THAT THE ABOVE NAMED STUDENT RESIDES AT THE ABOVE ADDRESS.

_____ _____

Signature of Parent/Legal Guardian Date

TRANSPORTATION

I hereby give consent for the above named student to compete in sports and be transported with a representative of the school on any trips.

_____ _____

Signature of Parent/Legal Guardian Date

I, _____ (Student's Name), understand that playing sports for Noli Indian School is a privilege. I agree to play by the rules and code of ethics set by CIP, Noli Indian School, and the Warrior League. I understand that it is my responsibility to turn in my uniform at the end of the season. If my uniform is not returned, I will have to pay for it or I will be forfeited the opportunity to participate in any other sports/activities offered at Noli.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Student Date

NOLI INDIAN SCHOOL

SOBOBA BAND OF LUISEÑO INDIANS

PREPARTICIPATION PHYSICAL EVALUATION

(To be completed by parent/guardian)

HISTORY

Name: _____ Sex: _____ Age: _____ DOB: _____

Grade: _____ School: _____ Sport(s): _____

Address: _____ Phone #: _____

Personal Physician: _____ Phone #: _____

In case of an emergency contact: Name _____

Phone #: _____ Business #: _____ Cell #: _____

Explain "Yes" answers below. Circle questions you don't know the answer to.

		Y	N
1.	Have you had a medical illness or injury since your last check-up or sport physical?		
2.	Have you ever had surgery?		
3.	Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using inhalers?		
4.	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?		
5.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects?		
6.	Have you ever had a rash or hives develop during or after exercise?		
7.	Have you passed out during or after exercise?		
8.	Have you ever been dizzy during or after exercise?		
9.	Have you ever had chest pains during and after exercise?		
10.	Do you get tired more quickly than your friends do during exercise?		
11.	Have you ever had racing of your heart or skipped heartbeats?		
12.	Have you ever had high blood pressure or high cholesterol?		
13.	Have you ever been told you have a heart murmur?		
14.	Have any family member or relative died of heart problems or sudden death before age 50?		
15.	Have you had severe viral infection (for example myocarditis or mononucleosis) within the last month?		
16.	Has a physician ever denied or restricted your participation in sports for any heart problems?		
17.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?		
18.	Have you ever had a head injury or concussion?		
19.	Have you ever been knocked out, become unconscious or lost your memory?		
20.	Have you ever had a seizure?		
21.	Do you have frequent or severe headaches?		
22.	Have you ever had numbness or tingling in your arms, hands, legs or feet?		
23.	Have you ever had a stinger, burner, pinched nerve?		

		Y	N
24.	Have you become ill from exercising in the heat?		
25.	Do you cough, wheeze, or have trouble breathing during or after activity?		
26.	Do you have asthma?		
27.	Do you have seasonal allergies that require medical treatment?		
28.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthopedics, retainer on your teeth, hearing aid?		
29.	Have you ever had problems with your eyes?		
30.	Do you wear glasses, contacts, or protective eye wear?		
31.	Have you ever had a sprain strain or swelling after injury?		
32.	Have you broken or fracture any bones or dislocated any joints?		

33. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?

If yes, check appropriate box and explain below:

☐ Head	☐ Upper arm	☐ Finger	☐ Ankle
☐ Neck	☐ Elbow	☐ Hip	☐ Foot
☐ Back	☐ Forearm	☐ Thigh	
☐ Chest	☐ Wrist	☐ Knee	
☐ Shoulder	☐ Hand	☐ Shin/Calf	

34.	Do you want to weight more or less than you do now?		
35.	Do you lose weight regularly to meet weight requirements for your sport?		
36.	Do you feel stressed out?		

37. Record the dates of your most recent immunizations (shots) for:

Td: _____ Measles: _____

Hep B: _____ Chickenpox: _____

38. **FEMALES ONLY:**

When was your first menstrual period? _____

When was your most recent menstrual period? _____

How much time do you usually have from the start of one period to the start of another? _____

What was the longest time between periods in the last year? _____

Explain "Yes" answers here: _____

NOLI INDIAN SCHOOL

SOBOBA BAND OF LUISEÑO INDIANS

PREPARTICIPATION PHYSICAL EVALUATION

(To be completed by a medical provider)

PHYSICAL EXAMINATION

Name: _____ DOB: _____ Date: _____

Weight: _____ Height: _____ Temp: _____ BP: _____ Pulse: _____ Resp: _____

Vision: R 20/___ L 20/___ Both 20/___ Corrected: ☐ Yes ☐ No Pupils: ☐ Equal ☐ Unequal

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulse		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Shoulder		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

CLEARANCE

☐ Cleared as of this date, I see no reason to exclude from sports.

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

_____

☐ Not Cleared for: _____

Recommendations: _____

_____

_____

Name of Physician (Please Print): _____

Address: _____ Phone #: _____

Signature of Physician: _____ MD/DO/PA-C/NP Date: _____

The information above must be filled in and signed by either a physician, a physician assistant licensed by the California Board of Physician Assistant Examiners, or a Register Nurse recognized as a Nurse Practitioner by the California Board of Nurse Examination. Form signed by any other health care practitioner will not be accepted.

NOLI INDIAN SCHOOL

SOBOBA BAND OF LUISEÑO INDIANS

AUTHORIZATION FOR PRESCRIBED AND OVER THE COUNTER MEDICATION ADMINISTRATION AT SCHOOLS WITHIN THE COUNTY OF RIVERSIDE

Name of Student	Date of Birth	Grade	School

Education code 49423 authorizes that any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designed personnel if the school district receives (1) written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent/guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement.

I request medication prescribed be administered to my student and agree to hold Noli Indian School, its officers and employees harmless from all liability or claims which might arise out of these arrangements. I give my permission to contact the physician for consultation as needed.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Home Phone Work Phone

PHYSICIAN AUTHORIZATION

ONE MEDICATION PER FORM

Name of Medicine(s)	Health Condition for which medicine RX
Time(s) to be taken	Dosage
Method of administration	Precaution-Possible untoward reactions
Date to be discontinued	Physician's Telephone Number
Name of Physician (Please Print)	Physician's Fax Number
Physician's Signature	Date

Please return this form to the school health office, signed by the physician and the parent or guardian.

THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR OR WHENEVER THERE IS A CHANGE IN MEDICATION OR INSTRUCTIONS. NO MEDICATION WILL BE ADMINISTERED WITHOUT THESE REQUIRED SIGNATURES.

PLEASE SEE RESPONSIBLITIES ON REVERSE SIDE.

NOLI INDIAN SCHOOL
SOBOBA BAND OF LUISEÑO INDIANS

VARSITY FOOTBALL
PARENT/GUARDIAN CONSENT FORM

To be filled out for 14 Year Olds Only

As the parent or legal guardian of _____

Student's Name

I permit him to participate in football at the varsity level at Noli Indian School.

_____ _____

Signature of Parent/Legal Guardian Date

NOLI INDIAN SCHOOL
SOBOBA BAND OF LUISEÑO INDIANS

VARSITY FOOTBALL
MEDICAL CONSENT FORM
To be filled out for 14 Year Olds Only

Student Name: _____

As a licensed medical practitioner, I certify that _____ is able
Student's Name
to participate in football at the varsity level.

_____ MD/PA-C/NP _____
Signature Date

Office Stamp

RIVERSIDE – SAN BERNARDINO COUNTY

INDIAN HEALTH, INC.

Pediatric Visit Questionnaire
11-17 years old

Teen's name: _____ Date of Birth: _____

Your name: _____ Date of Visit: _____

Relationship to teen: _____ HR#: _____

For us to provide you and your teen with the best possible health care, we would like to know how things are going. **Please answer all of the questions**. Thank you!

1. Do you have any questions or concerns today? _____

   _____

   _____

2. Has your teen been sick since your last visit? ☐ Yes ☐ No

   If yes, treatment received at:

   ☐ Home ☐ Urgent Care ☐ Emergency Room ☐ Hospitalization

   For what reason: _____

   _____

3. Have there ever been any major changes in your family or life lately? (Example: move, new living arrangement, new medical problem, job change, separation, divorce, death in the family, etc.) _____

   _____

Teen's Eating Habits

4. How many meals does teen eat per day? _____
5. Does teen eat breakfast every day? ☐ Yes ☐ No
6. Does teen have sources of calcium such as:

   ☐ soy milk ☐ almond milk ☐ whole cow milk ☐ reduced (1-2%) cow milk
   ☐ other milk _____ ☐ greens (ex. broccoli, kale, spinach) ☐ yogurt ☐ cheese
7. How many servings per day of fruits? ____ vegetables ____
8. How many servings per day of whole grains (ex. whole wheat bread, brown rice) ____

Teen's name: _____ Date of Birth: _____ HR: _____

9. How many servings per day of eggs? _____ beans? _____ meat? _____ tofu? _____
   Other sources of iron rich food such as raisins, dry peaches/apricots? _____
10. How much water does teen drink? _____ oz
11. How much juice does teen have? _____ oz
12. How much soda? _____ oz
13. How often does teen go out to eat per week? _____ times
14. Favorite snacks? _____

Teen's Preventative Health Screen:

15. Whom does teen live with? _____
16. Does teen always wear a seat belt in car? ☐ Yes ☐ No
17. Has teen started driving ☐ Yes ☐ No if yes, ☐ Permit or ☐ License (check one)
18. Does teen brush his/her teeth daily? ☐ Yes ☐ No
    a. When was teen's last dental visit? _____

Teen's Education:

19. What grade in school is teen in now? _____ grade
20. How is teen's performance? (check one)

    ☐ Excellent (A's) ☐ Good (B's) ☐ Average (C's) ☐ Needs Improvement (D/F)

21. Does teen have good friendships? ☐ Yes ☐ No/Unsure
22. Does teen have any experience with bullies? ☐ Yes ☐ No
23. What are teen's goals after high school? _____

Teen's Sleeping Habits:

24. What time does teen go to sleep? _____
25. How many hours does teen sleep? _____
26. Is teen rested when he/she wakes up? ☐ Yes ☐ No

Teen's name: _____ Date of Birth: _____ HR: _____

Teen's Activity:

27. What are teen's interests/talents/gifts (sports, reading, art, music, etc.)?

    _____

28. How often does teen exercise? _____ times a week For how long? _____ minutes
29. What kind of exercise? _____
30. How much time does your teen spend in front of the screen per day (ex. TV, computer, tablet, cell phone)? _____ minutes/hours

Teen Girls Only:

31. How old was teen girl when she had her first period? _____ years
32. How often is her period? _____ days
33. How many days does she bleed? _____ days
34. Does she have any symptoms with her period? ☐ Yes ☐ No
    a. If yes, what symptoms? _____
    b. What does she do/take to help symptoms? _____

Tuberculosis (TB) Screening:

35. Does the teen have a family member or contacts with a history of confirmed or suspected tuberculosis? ☐ Yes No
36. Is the child in a foreign-born family or have recent traveled to or from high-prevalence countries (Asia, African, Central and South America)? Yes No
37. Does the teen live with an adult with HIV seropositivity? Yes ☐ No
38. Does the teen live with an adult who has been incarcerated in the last 5 years? ☐ Yes ☐ No
39. Does the teen live with, or is frequently exposed to individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes? ☐ Yes ☐ No

Office Use Only:

Name of Doctor: _____

Doctor Signature: _____

RIVERSIDE – SAN BERNARDINO COUNTY INDIAN HEALTH, INC.

GENERAL CONSENT AND AUTHORIZATION FORM FOR A MINOR

CLINICAL CONSENT: The undersigned legal representative of a minor patient ("minor's personal representative") hereby consents to, authorizes, and requests the medical and related **services of Riverside-San Bernardino County Indian Health, Inc. (RSBCIHI) and its doctors, nurses, and other personnel, including without limitation any of the following clinical departments: Medical, Nursing, Dental, Obstetrical/Gynecological, Optometry, Nutrition, Behavioral Health, Laboratory, Pharmacy, Outreach, and X-Ray/Radiology.** The undersigned patient or minor's personal representative consents to the care. treatment. and procedures provided or performed by RSBCIHT and its personnel, which may now or during the course of the patient's care be deemed advisable or necessary, with the express understanding that RSBCIHI provides integrated services and care, and the patient's records and protected health information may be shared between RSBCIHI's Departments for treatment purposes.

RELEASE OF INFORMATION: The undersigned patient and/or minor's personal representative consents to the release of clinical and medical records and info11nation that is consistent with RSBCIHI's policies or procedures. RSBCll-11 only releases patient records and information in limited circumstances as authorized by law. The undersigned consents to release of records and information which RSBCIHI deems necessary and appropriate for the minor patient's care and treatment, including the promotion of integrated care between RSBCIHI's Departments; that is required or authorized by law; for purposes of obtaining third-party payment for the services provided to patient by RSBCIHI and its personnel, including other providers, institutions or agencies to which the patient is referred by RSBCIHI; OI", pursuant to a patient's or personal representative's written authorization.

ASSIGNMENT OF INSURANCE BENEFITS: The undersigned patient or minor's personal representative authorizes payment directly to Riverside-San Bernardino County Indian Health, Inc. of all insurance benefits for services and professional fees otherwise payable to or on behalf of the patient, but not to exceed the regular rates and fees for services rendered to the patient. **The undersigned agrees that should direct payment be received from an insurance carrier for services rendered by RSBCIHI, such payment is to be submitted to RSBCIHI upon 1·eceipt. Otherwise, the undersigned will be responsible to RSBCIHI for the amount of the payment.**

The undersigned irrevocably assigns and transfers to RSBCIHI all rights, benefits, and other interests in connection with any insurance plan, health benefit plan. or other source of payment for minor patient's care and treatment. This assignment shall include assigning and authorizing direct payment to RSBCIHI of all insurance and health plan benefits payable. The undersigned agrees that the insurer or plan's payment to the clinic pursuant to this authorization shall discharge its obligations to the extent of such payment. The undersigned accepts financial responsibility for charges not paid according to this assignment, to the extent permitted by law. and agrees to cooperate with, and take all steps reasonably requested by, RSBCIHI to perfect, confirm, or validate this assignment.

This form, when signed by a minor patient's personal representative, is valid for **<u>One Year</u>** unless revoked or modified in writing, replaced, or minor patient is no longer eligible for RSBCII-Il's services.

HR#: _____ Staff Initials: _____

RIVERSIDE – SAN BERNARDINO COUNTY INDIAN HEALTH, INC.

GENERAL CONSENT AND AUTHORIZATION FORM (MINOR PATIENT)

_____ _____ _____
Minor Patient's Name Date of Birth Age

_____
Name of Minor Patient's Personal Representative

_____
State Legal Relationship to Patient
(I.e. Parent/Guardian/Authorized Caregiver)

_____
Documentation Verifying Legal Relationship to Minor Patient Provided (Y/N) (Required)

Names of Other Relatives/Caregivers/Authorized Persons that Legal Representative Formally Designates as Authorized to Consent to Non-Emergency, Routine Care Provided by RSBCI HI on Behalf or Minor Patient. Please State Relationship to Minor. Including Any Limitations to Authorization.

_____

_____

I solemnly swear I have the authority to act as the Minor Patient's Personal Representative and have provided the necessary documentation to that effect. I also acknowledge and understand I have the following rights and responsibilities as the Minor Patient's Personal Representative: I) I may revoke or modify this authorization in writing at any time; 2) I have the right to receive a copy of this authorization: 3) I must provide RSBCIHI with any new information regarding who may or may not be authorized lo consent lo care on Minor's Patient's behalf. including without limitation: a) Divorce decree: b) Custody Orders; c) Official Court documentation. such as an Adoption Decree or Legal Guardianship, from a State of Tribal Court; d) Designation of Indian Custodianship; e) Caregiver Affidavit; and any other formal documentation that would provide another person, or remove from Affidavit: and. any other formal documentation that would provide another person. or remove f om an authorized person, the right to consent to medical care on Minor Patient's Behalf. I ackJ1owledge that this is an ongoing duty, and it is my responsibility to keep RSBCIHI informed of any changes to my authority or any other authorized person's authority. to consent to Minor's care. I further understand that I, or another authorized representative, must be present on RSBCIHI's premises while Minor Patient receives care at all times unless the minor may consent to the services, or as otherwise authorized by law. I finally acknowledge that I have received a Notice of RSBCIHI's Privacy Practices.

_____ _____
Signature of Minor Patient's Legal Representative Date

_____ _____ _____
Date of Authorization Date This Authorization Expires HR#

HR#: _____ Staff Initials: _____
Universal Form #99-032 (rev'd 2019)
WHITE-Health Record CANARY-Patient Copy