Ptarmigan Connections, LLC
3505E Meridian Park Lp, Ste 200, Wasilla, AK 99654
907-357-4400 (office) 907-357-4410 (fax)
ptarmiganconnections.com

Parental Consent for Treatment

►Child's Information

1. Child's Name _____ Date of Birth _____

2. Child's Name _____ Date of Birth _____

3. Child's Name _____ Date of Birth _____

Home Mailing Address _____ Primary Phone Number _____

City, State, Zip _____

Special Information (Special medical conditions, sensitivities to medication, allergies):

_____

The below named custodian(s) is/are acting in *loco parentis* and shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures (including administration of anesthesia, diagnostic tests, etc.), for the above named child, which may be required during my absence.

[_____] By initialing on this line, I agree that the custodians below shall also be authorized to consent for any agreed upon neuropsychological testing and evaluation by licensed staff at this facility.

►Custodian's Information

Custodian's Name _____ Relationship to child _____ Phone Number _____

Custodian's Name _____ Relationship to child _____ Phone Number _____

Custodian's Name _____ Relationship to child _____ Phone Number _____

This consent serves as permission for treatment at **PTARMIGAN CONNECTIONS, LLC.**
Note: Consents are not required in emergency situations.
I agree to pay for all services provided to my child in my absence.
This authorization shall be effective until: **One year** from the date beside my signature

►Signatures

Print Parent / Legal Guardian's Name (circle one) _____ Phone Number (Cell / Work) _____

Signed Parent / Legal Guardian (circle one) _____ Date _____

Witness _____ Date _____