Polson Health
KALISPELL REGIONAL HEALTHCARE
WELLNESS | WALK-IN CARE | SPECIALTY CARE

I _____, as parent or legal guardian of _____ with a date of birth of ___/___/___ give my permission for him/her to seek medical treatment at Polson Health as needed.

_____
Signature of parent or legal guardian

_____
Print name of parent or legal guardian

_____ ___/___/___
Relation to Minor Date