Coddington Medical Family Practice, LLC

PERMISSION TO SEEK MEDICAL CARE FOR MINOR CHILDREN WHEN PARENT/GUARDIAN IS NOT AVAILABLE.

I, ____ the parent or legal guardian of

(Print name of parent/guardian)

____ give permission for

(Minor child's name)

____ to seek medical care and sign the appropriate

consent forms that are necessary to carry out the treatment for my minor child during my absence.

_____________________________________ ___________________

Signature of Parent/Guardian Date

____

Witness

This form shall remain valid for one (1) year from date of signature.

Coddington Medical Family Practice, LLC

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Lincoln, NE 68522