CMFP

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
1336 West A St, Suite A
Lincoln, NE 68522