6969 South St | Lincoln, NE 68506 | 402-413-7460
Casey D Bowen, MD ● Gina L Weir, MD ● Jay Arthur, PA-C ● Christina Meyer, PA-C

Consent to Treat Minor without Parent/Legal Guardian Present

By law, any child under the age of 19 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that the person has been appointed by you to act on your behalf.

Patient Name (Minor): ____ **Date of Birth:** ______________

I appoint the following individuals to give consent to treat my child:

____ __________________________________
First Name Last Name Relationship to Patient

____ __________________________________
First Name Last Name Relationship to Patient

LIMITATIONS:
The following are limitations to the kinds of medical services for which this authorization is given. If there are no limitations, state "none." ____
____

☐ Check here if you wish to give consent for the minor to receive medical care **without an accompanying adult.** This consent may only apply to minors age 16 and older.

This consent shall be in effect until: ☐ Date (MM/DD/YYYY) ____________________________
☐ Indefinitely, until revoked with written communication

AUTHORIZATION:
I request and authorize Dermatology Associates of Lincoln, LLC and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in their diagnosis and treatment.

I have the legal right to preauthorize Dermatology Associates of Lincoln, LLC to deliver routine medical treatment and services to my child. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, injections, lab work, blood draws, wart treatment, use of liquid nitrogen, etc. I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

____ ______________________
Signature of Parent or Legal Guardian **Date**

____ _________________________
Parent/Legal Guardian Name (Printed) **Relationship to Patient**

Updated on 12/16/2020