



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 • Meredith McManaman, PA-C

Consent to Treat Minor without Parent/Legal Guardian Present

By Nebraska law, any child under 19 years of age cannot receive medical care without consent from a parent or legal guardian. If someone other than a parent or legal guardian accompanies a child to their appointment, we must have written permission from the parent or legal guardian appointing that person to act on their behalf.

Patient Name (Minor): _____ **Date of Birth:** _____

I, _____, appoint the following individual(s) 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." _____

By checking here, I give consent for my minor child 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**