FP Associates, P.C.
1103 Galvin Rd S, Ste G
Bellevue, NE 68005
402-292-1072

Parental Consent for Medical Treatment

Child's Information

____ _____________________
Child's Name DOB

____ ______________________
Home Address Home Phone Number

____
City, State, Zip Code

____ _______________________
Parental Contact Phone Number

Please contact me at the following telephone number ___________________________ if needed.

This consent serves as permission for treatment by FP Associates, PC.
Note: Consents are not required in emergency situations. I agree to pay for all services provided to my child in my absence.

[ ] This consent for medical treatment is valid for 12 months and may be canceled at any time.

[ ] This consent for medical treatment is valid for _______________________________________

Adult Caregiver Information

____ ________________________
Caregiver's Name Phone Number

The above named caregiver shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures (including administration of medication by injection, immunizations, diagnostic tests, etc.), for the above named child, which may be required during my absence.

Signature

____ _______________________
Parent/Guardian Date