BUTLER COUNTY CLINIC, P.C.

Mark V. Carlson, MD
Matthew P. Summers, MD
Robert A. Daro, MD

Spanning the Generations…

Gerald W. Luckey, MD
Joshua J Sypal, MD
Leah J. Hays, PA-C

Consent for Emergency/Medical Treatment of a (Minor) Child

I, _____, parent or legal guardian of_____, _____, _____, born on_____, _____, _____, consent and allow permission to _____, relationship_____, to handle any type of medical care for my child, including diagnostic procedures, lab work, shots (excluding vaccinations), surgical and medical treatment, as necessary. Consent starting on _____ and ending on_____.

I acknowledge that I am responsible for all reasonable charges in connection with the care and treatment of my (minor) child.

_____ _____ _____
Signature of Parent or Legal Guardian Date Print Name

_____ _____ _____
Signature of Witness Date Print Name

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Father's Telephone: _____ Mother's Telephone: _____

Allergies to drugs or foods: _____

Medications or Pertinent Information: _____

_____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy # _____

336 South 9th Street * David City, NE 68632
Phone: 402-367-3193 * Fax: 402-367-3261