Omaha Childrens Clinic P.C.

Delegation of Consent

Name of Patient: _____ DOB: _____
Name of Patient: _____ DOB: _____
Name of Patient: _____ DOB: _____
Name of Patient: _____ DOB: _____
Name of Patient: _____ DOB: _____

I hereby authorize (when I am unavailable to give consent) the following individual(s)

Name: _____ Relationship to Child: _____

Name: _____Relationship to Child: _____

Name: _____Relationship to Child: _____

Name: _____Relationship to Child: _____

To consent to any and all medical care and attention deemed necessary and appropriate for this minor by a healthcare provider licensed in the state of Nebraska. This consent includes, but is not limited to, medical and surgical intervention and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent.

Signature of Parent/Guardian:

_____

Relation to Patient: _____ Date: _____

Witness: _____ Date: _____