Fallbrook Family Health Center

PHONE (402) 441-3575

FAX (402) 438-2107

AUTHORIZATION FOR TREATMENT OF A MINOR (19 years of age or younger)

This form grants temporary authority to Fallbrook Family Health Center to provide and arrange for medical care of a minor, where the minor is not accompanied by either parent/legal guardian(s) and it may not be feasible or practical to contact them.

Minor Child

Full Legal Name: _____ Date of Birth: _____

Home Address: _____ Gender: Female Male

Information for Medical Treatment

Location of Practice: **Fallbrook Family Health Center 755 Fallbrook Blvd., Suite 100 Lincoln, NE 68521**

Medical Insurer/Health Plan: _____

Allergies to Medications: _____

Allergies (Other): _____

Please note **all** conditions for which the child is currently receiving treatment during scheduled visit:

_____

Note any other significant information:

_____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for **Fallbrook Family Health Center** to administer medical treatment for any minor injuries or illnesses experienced by the Minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, or medical professional licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care. It is understood that this authorization is given in advance of any such medical treatment but is given to provide authority and power on the part of **Fallbrook Family Health Center** in the exercise of their best judgment upon the advice of any such medical or emergency personnel.

Parent / Legal Guardian Signature: _____ Date: _____

Parent / Legal Guardian Printed Name: _____

Phone Number of parent / legal guardian to be reached at during appointment: _____