Omaha Orthopedic Clinic &
Sports Medicine P.C
11704 W. Center Road Suite #200
Omaha, NE 68144
Phone (402) 691-0500 Fax (402) 691-1586

CONSENT TO TREATMENT OF A MINOR

IN ABSENCE OF PARENT /GUARDIAN

I hereby authorize examination and treatment of _____, a minor patient, by physicians of Omaha Orthopedic Clinic & Sports Medicine, P.C. and any assistants or designees deemed necessary by the physician. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as the results of treatments or examinations at this clinic.

_____ _____
Signature of Parent/Guardian Date Relationship

_____
Signature of Witness Date

This authorization is effective from_____ to _____.
month/day/year month/day/year

TELEPHONE/VERBAL CONSENT TO TREATMENT OF A MINOR

I, _____, an employee of Omaha Orthopedic Clinic & Sports Medicine, P.C.,
(Name)

have obtained verbal permission from _____, _____,
(Name) (Relationship)

for examination & treatment of _____, a minor, prior to any medical
(Patient's Name)

services being performed.

Date of verbal Consent: _____
month/day/year