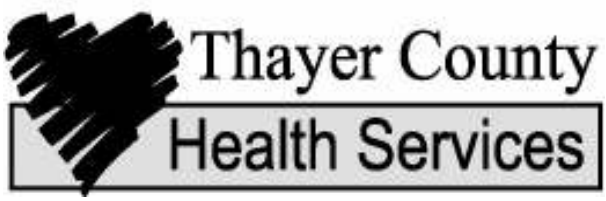

120 Park Avenue, Hebron, NE 68370
Phone: 402-768-7203 Fax: 402-768-4672

PERMISSION TO SEEK MEDICAL TREATMENT FOR MINOR CHILDREN WHEN PARENT/GUARDIAN IS NOT AVAILABLE.

I, _____ the parent or legal guardian of
(Print name of parent/guardian)

_____ give permission for
(Print minor child's name)

_____ to seek medical care and sign

the appropriate consent forms that are necessary to carry out treatment of my minor child in my absence.

_____ _____
(Signature of parent/guardian) (Date)

_____
(Witness)

THIS FORM SHALL REMAIN VALID FOR ONE (1) YEAR FROM DATE OF SIGNATURE.