Consent to Treat Minor

ENT Professional Services, PC
3385 Dexter Ct. Suite 101
Davenport, IA 52807
563-359-1646 (phone)
563-232-8891 (fax)
www.entprofessional.com

Minor Patient's Name _____

Patient's Date of Birth _____

Parent/Legal Guardian's Name _____

Relationship to the patient_____

As the parent/legal guardian of the above-named minor patient, I acknowledge the patient is less than 18 years of age, and I have the authority to and hereby give my consent and permission for the treatment to the patient in the office of ENT Professional Services, PC, as well as the administration of any emergency medical treatment deemed necessary in association with the visit, in my absence, whether such emergency treatment is administered in the office of ENT Professional Services, PC or at a designated facility. Authorization is also given to request the services of an ambulance at the expense of the parent/legal guardian should such transportation to the hospital be deemed necessary by the doctor and his staff.

This authorization shall remain effective through _____

_____ _____
Signature (Parent/Legal Guardian) Date