LAKESIDE ALLERGY, EAR, NOSE & THROAT

CONSENT FOR MEDICAL TREATMENT OF A MINOR CHILD IN THE ABSENCE OF A PARENT OR GUARDIAN

I (We) _____ and _____
(Name) (Name)

Of _____
(City, County, State)

do hereby state that I am (we are) the parent (s) or legal guardian of:

_____, a minor age _____, born _____/_____/_____
(Name)

Who resides with me (us) at _____
(Address, City, State)

In my absence, I (We), authorize _____, an adult who resides
(Name)

at _____
(Address, City, State)

to consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/ or care to be rendered to the above-named minor under the general or special supervision and on the advice of the physician of Lakeside Allergy, Ear, Nose & Throat.

Dated this _____ day of _____, 20____.

_____ _____
Signature of Parent or Guardian Signature of Parent or Guardian

_____ _____
Witness Name Printed Date

_____
Witness Signature

Fax: 972.771.5444