Allergy & ENT Specialists of Central Florida

Consent for Treatment of Minor (less than 18 years of age)

_____ _____

Name of minor patient (please print) *Date of birth*

Consent by Parent/ Legal Guardian:

By signing below, I acknowledge that I:

1. Am the parent or legal guardian of _____(Minor),
2. Have the legal authority to consent for the evaluation and treatment of this minor,
3. Authorize all diagnostic, medical and/or surgical treatment of this minor as the physician of Allergy, Ear, Nose, & Throat Specialists of Central Florida consider necessary or appropriate under the circumstances for the treatment of any medical condition, and
4. Authorize that treatment may be provided in my absence.

This consent shall remain in effect unless revoked in writing.

_____ _____

Name of Parent/Guardian (please print) *Relationship*

_____ _____

Parent/Guardian signature *Date signed*

_____ _____

Witness signature *Date signed*

Consent by Minor Patient:

By signing below, I acknowledge that I:

1. Consent to all diagnostic, medical and/or surgical treatment by the physicians of Allergy, Ear, Nose, & Throat Specialists of Central Florida

_____ _____

Signature of minor patient *Date signed*

_____ _____

Signature of witness *Date signed*