Ear
Nose
&Throat
Associates
of Manatee, P.A.

PARENTAL CONSENT FOR TREATMENT & CARE OF MINORS

I,_____ being the parent and/or legal Guardian of
Print Name

the minor age child, _____ _____
Print Name Date of Birth

hereby give consent for medically necessary treatment and care by the health care providers affiliated with Ear, Nose & Throat Associates of Manatee, P.A. Care to include all in-office, minor procedures and prescribed medications. In the event I am not available at a time this minor requires medical care, I give parties listed below the authority to seek and authorize care.

*Consent is only valid if signed and dated by **both** the Parent/Legal Guardian and a Witness that is over the age of 18.*

_____ _____
Signature of Parent/Legal Guardian Date

_____
Print Name of Parent/Legal Guardian

_____ _____
Signature of Witness Date

_____ _____
Print Name of Witness Date of Birth

ALTERNATE PARTIES AUTHORIZED TO SEEK MEDICAL CARE FOR MINOR CHILD

1) _____ _____
Print Name Relationship

Work Phone: _____ Home Phone: _____ Initial of Legal Guardian: _____

2) _____ _____
Print Name Relationship

Work Phone: _____ Home Phone: _____ Initial of Legal Guardian: _____

This consent will remain in effect for one year from the date the consent was signed.