CAROLINA
EAR NOSE & THROAT
SINUS AND ALLERGY CENTER, P.A.

Minor Child Consent for Treatment

I, _____, as parent/guardian of
(Full Name of Parent/Guardian)

_____,
(Full Name of Minor)

do hereby authorize Carolina ENT-Sinus and Allergy Center, PA and Carolina Sinus and Allergy the permission to do necessary health services to the minor listed above in my absence. This authorization shall be valid for one year commencing on _____ and ending one year from this date.

Below is a list of people who are allowed to bring in my child for treatment:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

_____ _____
Signature of Parent/Guardian Date

_____ _____
Witness Date

If this form is not completed in our office by a parent it will need to be notarized