Ear Nose & Throat
CONSULTANTS, LLC

Phone: 402-778-5250
Fax: 402-778-5216

Parent (Legal Guardian) Consent to Treat a Minor Child

Patient Name: ______________________________

Patient DOB: ______________________________

Relationship to Patient: ______________________________

Today's Date: ______________________________

I hereby give my permission to evaluate and treat the above named patient.
(Consent not to exceed a period of one year from the date above).

Parent/Guardian Signature: ______________________________

Parent/Guardian Printed Name: ______________________________