

# MEDICAL TREATMENT FOR MINOR CHILD

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I, \_\_\_\_\_, Parent or Legal Guardian of

\_\_\_\_\_, a minor child, hereby authorize any Medical or Surgical treatment which may be necessary in an emergency, and/or in my absence, for the well being of the above mentioned minor. I agree to hold Ear, Nose, and Throat & Allergy Specialists treating the above mentioned minor, harmless.

Signature: \_\_\_\_\_

Address and contact information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

The above mentioned minor has the following allergies or Medical conditions

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

This information will be updated annually.