Southern Missouri ENT & Allergy

1409 Doctors Drive
West Plains, MO 65775
417-255-1373

PARENTAL CONSENT FORM

Child's Name _____ Date of Birth _____

The undersigned does hereby give permission for the above named child to be examined and treatment rendered in the office of Southern Missouri ENT & Allergy.

I authorize the listed adults, in whose care the minor will be entrusted, to consent to any medical treatment, surgical treatment, and/or hospital care, to be rendered to the minor, based on the advice of any physician licensed under the state medical board and the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the physician office or the hospital.

Authorized Persons:

I understand that I will be liable and agree to pay expenses incurred in connection with such medical services rendered to the aforementioned child pursuant to this authorization.

_____
Parent or Guardian (Print)

_____ _____
Signature Date

_____ _____
Witness Date