



Permission to Treat

Parent/Guardian name _____

Person accompanying child _____

Relationship to child _____

Child's name _____ DOB _____

- I give permission for the above named person to accompany my child to his/her office visit.
- I give permission for the provider to administer immunotherapy injections to my child.

Parent/Guardian signature: _____ Date: _____

If no Parent/Guardian is present consent must be given over the phone.

Patient Advocate signature: _____ Date: _____

Medical Assistant signature: _____ Date: _____

www.southvalleyent.com

West Jordan

3584 W. 9000 S., Suite 311
West Jordan, UT 84088
(801) 566-8304

Murray

5169 S. Cottonwood St., Suite 310
Murray, UT 84107
(801) 507-3444

Riverton

4651 W. 13400 S., Suite 120
Riverton, UT 84096
(801) 562-9350