SOUTH VALLEY
EAR NOSE & THROAT

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: _____