Rocky Mountain Pediatric ENT Associates

Consent for Treatment without Parent/Guardian Present

Patient Name______________________________ DOB_____________ Today's Date_____________

Parent/Legal Guardian Name______________________________ Contact #_____________________

I, ________________________________, give consent for ____________________________ to obtain
Parent/Guardian Authorized Individual

medical treatment for my child, __________________________. This may include physical
Child

examination, lab work, medication injections/infusions, and/or any other treatment deemed necessary

my child's treating provider.

*This consent will remain in effect unless revoked in writing by parent or guardian.