Lawrence Otolaryngology Associates, LLC
1112 West 6th St, Ste 216
Lawrence, KS 66044

Chart# _____

Medical Treatment for Minor Child

Patient Name: _____ Patient DOB:_____ Date: _____

I, _____, Parent or Legal Guardian of above listed patient, a minor child, hereby authorize 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 also assume the responsibility for the payment of any such treatment. I understand that I may revoke this consent at any time in writing. This release is effective for the period of one year from the signed date below unless I specify a date here: _____.

The following person(s) is designated to act on my behalf:

Name: _____ Relationship_____

Address _____ City/State_____

Primary Phone # _____ Secondary Phone # _____

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Name: _____ Relationship_____

Address _____ City/State_____

Primary Phone # _____ Secondary Phone # _____

****

Name: _____ Relationship_____

Address _____ City/State_____

Primary Phone # _____ Secondary Phone # _____

****

Patient/Guardian/ Signature: _____Date: _____