EASTERN SHORE
ENT & Allergy
ASSOCIATES, P.A.

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PARENTAL DESIGNATION FORM AUTHORIZING TREATMENT OF A MINOR

I, _____ am the:
Print your name

- ○ Natural or adoptive parent of
- ○ Guardian of
- ○ Person, who, under court order, is authorized to give consent for

The minor, _____ Date of birth___/___/___
Print the name and date of birth of the minor

I authorize, Eastern Shore ENT & Allergy Associates, PA, to discuss and provide medical treatment of the above named minor with the following authorized adult(s) (ie: grandparents, adult siblings, adult aunt/uncles, step-parents, etc):

Name:_____ Relation to Minor:_____

Name:_____ Relation to Minor:_____

Name:_____ Relation to Minor:_____

Name:_____ Relation to Minor:_____

Name:_____ Relation to Minor:_____

_____ _____
Signature of Parent or Guardian Witness

_____ _____
Date Date