EASTERN SHORE
ENT & Allergy
ASSOCIATES, P.A.

NATHAN DECKARD · MICHAEL KELLEHER
DANIEL KELLEY | M.D., F.A.C.S.
LAURA KING | P.A.
ETHAN CRAIG | P.A.-C

Salisbury Office: (410) 742-1567
Berlin Office: (410) 641-4582
Cambridge Office: (410) 901-3433

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, P.A. to discuss and provide medical treatment for the above-named minor with the following authorized adult(s) (e.g., grandparents, adult siblings, adult aunts/uncles, stepparents, etc.):

Name _____ Relation to Minor _____

Name _____ Relation to Minor _____

Name _____ Relation to Minor _____

_____ _____
Signature of Parent or Guardian Witness

_____ _____
Date Date

Revised December 2023