



**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: \_\_\_\_\_

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[www.southvalleyent.com](http://www.southvalleyent.com)

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#### Murray

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