Lemont ENT, S.C.
Cynthia Go, MD, PhD, FACS
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(630) 243-4505
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CONSENT FOR TREATMENT OF CHILD/MINOR

I affirm that I am the parent, guardian, or personal representative of

_____,

And there are not court orders now in effect that prohibit me from signing this consent.

I do hereby request and authorize Dr. Cynthia Go to perform necessary services detailed below (please check all applicable) which are deemed advisable by the doctor for the child/minor named above, whether or not I am present when the services are rendered.

Medical advice regarding diagnosis and treatment

Prescription medication

Laboratory evaluation for diagnosis

Radiology evaluation (x-rays, ultrasound, etc.) for diagnosis

_____ _____
Signature of Parent or Guardian Date

_____
Printed Name of Parent or Guardian