6133 POPLAR PIKE
MEMPHIS, TN 38119
PHONE: (901) 761-9720 / FAX: (901) 680-1992

PARENTAL CONSENT FORM

Child's Name ___________________________ Date of Birth ___________________

The undersigned does hereby give permission for the above named child to be examined and treatment rendered in the offices of Shea Ear Clinic.

I authorize the listed adults, in whose care the minor will be entrusted, to consent to any medical treatment, surgical treatment, and/or hospital care, to be rendered to the minor, based on the advice of any Shea Ear Clinic physician licensed under the state medical board and the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the Shea Ear Clinic or the hospital.

Authorized Persons:____

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I understand that I will be liable and agree to pay expenses incurred in connection with medical services rendered to the aforementioned child pursuant to this authorization.

____
Parent or Guardian (Print)

_____________________________________ ____________________
Signature Date

_____________________________________ ____________________
Witness Date