2301 Newnan Crossing Blvd E, Ste 120

Newnan, GA 30265

770-683-4155

Consent for Medical Treatment of a Minor Child

I, ___________________________________ of ___________________________________,
(Parent or legal guardian) (Street address)

___________________________, __________, ____________________, do hereby state that I am the parent
(City) (State) (Zip)

of ____, a minor, age_________, born
(Minor child's name) (Age)

_______________, who resides with me at ____,
(Date of birth) (Street address)

____________________________, _________, ____________.
(City) (State) (Zip)

I ______________________________________, an adult, who resides at
(Name)

____________________________________, _________, ___________ consent to any physician at McClinton ENT of Newnan, LLC
(Street address) (State) (Zip)

rendering any necessary examination and treatment, both medical and surgical, including hospital care, to the above-named minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the state of Georgia.

Dated this __________________________ day of ___________________________, 20_____.

_____________________________________ _______________________________________

(Signature of parent or guardian) **(Signature of witness)**