Ohio ENT & Allergy Physicians
SLEEP DIVISION

Minor Waiver

Patient Name:

As the legal parent/guardian of patient _____, I am authorizing this minor to attend his/her appointment at Ohio ENT & Allergy Physicians- Sleep Division without my presence. I give consent for _____ - _____ to attend this appointment with my minor
Patient Representative Name Relationship to Patient

in my absence. I understand Ohio ENT and Allergy Physicians is not responsible for supervision of this minor and I hold Ohio ENT and Allergy Physicians harmless. I give my consent to Ohio ENT & Allergy Physicians-Sleep Division to follow their emergency protocol if urgent medical care should be needed.

I can be reached at the following number during the time of this minor's appointment_____.

_____
Print name of parent/legal guardian

_____
Signature of parent/legal guardian Date