



**FLORIDA
ENT** ADULT & PEDIATRIC, PA

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FELLOW AMERICAN ACADEMY OF OTOLARYNGOLOGY

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OTOLARYNGOLOGY – HEAD & NECK SURGERY – EAR & SINUS SURGERY – FACIAL PLASTIC & SKIN CANCER SURGERY – THYROID SURGERY

CHILD CONSENT.

I _____ give my permission for _____
(Parent/Guardian Name) (Child Caretaker)

To bring my child _____ to the physician at FI ENT for medical treatment and
(Child's Name)

To sign any necessary paperwork (including medical/surgical & insurance assignments) pertaining to

My child. I also give my permission to make any and all medical decisions for the care of my child.

Signature

Date

Witness

Date