Dina Ezagui MS, CCC-SLP TSHH, QOM
MS-Ed, SBL/SDL
dinaezslp@gmail.com

CONSENT TO TREAT MINOR CHILDREN

I, _____, parent or legal guardian of _____, born

the ___ day of _____, 20___ do hereby consent to speech/myofunctional therapy services provided by Dina Ezagui, MS CCC-SLP. Services will be provided at 709 Eastern Parkway, Brooklyn NY, 11213

This authorization is effective from the ___ day of _____, 20___

I give permission to Dina Ezagui to speak on my child's behalf to the following medical doctors, therapists, teachers (please indicate phone numbers or email addresses):

_____
_____
_____

_____ _____
Signature of Parent or Legal Guardian **Date**

_____ _____

Family Address _____

Father's Telephone: _____ Mother's Telephone: _____

Emergency Contact person _____ Relationship to the child_____

Phone Number_____