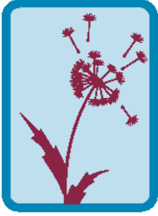

Allergy & Asthma Associates of Southern California

Leading-edge, personalized care you can trust

AUTHORIZATION TO TREAT A MINOR

I, ____________________________ , parent of __________________________ , authorize _________________________________ , telephone _____________________ , who is related to me as my___________________________________to bring my child to their appointments at Allergy & Asthma Assoc. of Southern California. I grant them permission to authorize treatment for_______________________________________as (s)he deems necessary. I consent to and authorize any qualified medical practitioner to render such medical treatment to my child as such practitioner deems necessary. As the parent/legal guardian, I agree to promptly pay for all such services and treatment.

I may be reached at ____________________(office) or ____________________(home).

Our address is ____.

I have __________________________medical insurance, # ______________________.

DATED: ________________________ ____________________________________

(Signature of Parent/Legal Guardian)

NOTE:

Family Doctor : _____________________________ Tel: ___________________________

Hospital : __________________________________ Tel: ___________________________

Neighbor: __________________________________ Tel: ___________________________

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