



**Allergy & Asthma
Associates
of Southern California**

Leading-edge, personalized care you can trust

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AUTHORIZATION TO TREAT 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: _____
(Father) (Mother)

NOTE:

Family Doctor : _____ Tel: (____) _____

Hospital : _____ Tel: (____) _____

Neighbor: _____ Tel: (____) _____

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