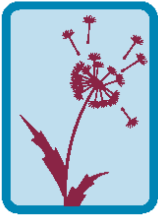

Allergy & Asthma Associates of Southern California

Leading-edge, personalized care you can trust

William E. Berger, M.D.
Warner W. Carr, M.D.
Mark S. Sugar, M.D.
Christina D. Schwindt, M.D.

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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