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: (____)_____