allergy & asthma
Medical Group of The Bay Area, Inc.

Adult Allergy

Pediatric Allergy

Clinical Immunology

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# Authorization to Consent to Treatment of a Minor

I *(we)*, the parent(s)/guardian(s) of the minor listed below do hereby authorize

_____
(adult into whose care minor is entrusted)

To act in my (our) place to consent to all necessary and appropriate examinations, medical diagnosis or treatment and emergency care which is deemed advisable by and is to be rendered under general or special supervision of any physician or nurse practitioner licensed at Allergy & Asthma Medical Group.

It is understood that this authorization is given in advance of any specific diagnosis or treatment but is given to any physician to exercise the best medical judgment that is deemed advisable and in the best interest of the child.

Child Name _____ Date of Birth _____ Allergies

_____

Our address and phone number is:

_____

Medical Insurance Company or Plan: _____

Policy Number:_____ Group #:_____

I (we) assume all financial responsibility for the delivery of such care.

_____
(Signature of Parent) Date

_____
(Signature of Parent) Date