Mid-Cities Allergy & Asthma Center

CONSENT FOR MEDICAL TREATMENT OF A MINOR

The policy of Mid-Cities Allergy & Asthma Center states that "**any minor undergoing a medical evaluation or treatment must be accompanied by a parent or legal guardian at all times**." The purpose of this policy is to ensure efficient and timely execution of medical advice and treatment plans; the goal of which is to serve the best interest of the minor. However, under certain circumstances this policy can be rescinded with the expressed written consent of a parent or legal guardian.

Authorization to Treat a Minor

I ______________________________, the parent or legal guardian of the following minor child or children:

Name of Minor: ____________________________ Date of Birth: _________________

Name of Minor: ____________________________ Date of Birth: _________________

Name of Minor: ____________________________ Date of Birth: _________________

…… give my consent allowing the following people to seek medical care for the above listed child/children in the event that I or another legal guardian is absent:

Consent Granted To:

Name: ____________________________ Relationship to Minor: __________________

Name: ____________________________ Relationship to Minor: __________________

I acknowledge that in order for Mid-Cities Allergy & Asthma Center to administer allergy injections or other treatment to my child in my absence, I must give my permission. All questions that I have concerning the treatment of a minor in the absence of a parent or legal guardian have been answered to my satisfaction. I am aware that I have the right to withdraw my consent for any reason and at any time upon written notice of this desire. I hereby state that I have read and understand this consent and I have affixed my signature attesting to the same.

___________________________________ ___________________________________

Printed Name of Parent or Legal Guardian Signature of Parent or Legal Guardian / Today's Date