



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: _____

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

Diplomates of the American Board of Allergy and Clinical Immunology

370 N. Wiget Lane • Suite 210 • Walnut Creek, CA 94598 • 925/935-6252
2305 Camino Ramon • Suite 225 • Bishop Ranch 11 • San Ramon, CA 94583 • 925/327-1450
5924 Stoneridge Drive • Suite 207 • Pleasanton, CA 94588 • 925/463-9400
350 John Muir Parkway • Suite 180 • Brentwood, CA 94513 • 925/513-3140
3010 Colby Street • Suite 221 • Berkeley, CA 94705 • 510/644-2316
1761 Broadway Street • Suite 203 • Vallejo, CA 94589 • 707/278-9360

www.bayareaallergy.com