Parent / Legal Guardian Consent for Evaluation & Treatment of Minor Child

If a parent or legal guardian will not be accompanying a minor (less than 18 years old), the parent or legal guardian must complete this form.

Patient Name: _____ Office: _____

Patient Date of Birth: _____

I, (name of parent or legal guardian) _____
hereby give permission and consent for my

minor child, (name) _____ to be evaluated and treated at The Asthma Center in my absence. The evaluation and treatment may include, but is not limited to:

- to be examined and treated during a medical office visit by The Asthma Center Provider(s)
- to undergo allergy skin testing
- to receive allergy / venom / biologic / vaccine injection(s)
- to undergo a scheduled procedure (i.e rhinoscopy, patch testing, etc.)
- to undergo a Methacholine Challenge or a Complete Pulmonary Function Test

I will provide my child with my emergency contact number prior to each visit at The Asthma Center. I am aware that there may be potential side effects, and/or adverse reactions for the evaluation and/or treatment.

In my absence, the following person(s) will be accompanying my child to The Asthma Center: _____,

(relationship to child) _____ .

I also give my permission to the person(s) accompanying my child to have access to my child's personal health information on the day of the visit to The Asthma Center.

In the event of a reaction to any injection(s), procedure(s) and/or testing, I give my consent to the provider(s) and the staff at The Asthma Center to provide my child with the necessary medical treatment(s). I understand, if necessary, that this treatment may include a 911 call and treatment at the local hospital emergency department.

_____ _____
Parent or Guardian Signature Date

_____
Emergency Contact Telephone Number

_____ _____
Witness Signature Date