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Allergy Associates of the Palm Beaches

Adult/Pediatric Allergy & Immunology

Guardian Permission for Treatment of Minor

You and your child's physician have discussed a proposed course of treatment for _____ (Name of child)

You have indicated, and your doctor concurs, that you wish your child to assume the limited responsibility of coming to our office for their treatment accompanied by _____ **(**Name of person authorized to accompany child) as your agent to consent to the following (initial as pertinent):

_____ Series of allergy shots
_____ Office visit/examinations
_____ Pulmonary function tests (pft)
_____ Immunizations (ie flu shot)
_____ Breathing treatment(s)
_____Emergency treatment of allergic reaction or asthma
_____ Other

_____ You are acknowledging by your signature that the risks, benefits, and alternatives to the treatment(s) or examinations checked above have been explained to you. You understand that this authorization is given to provide your authority and power to your agent to give specific consent to any and all evaluations, diagnosis, and treatment or care that they, in the exercise of their best judgment, may deem advisable.
This authorization also grants to your agent the power to sign for release of information to any third party payors who may be responsible for part or all of the cost of the services provided.
Please feel free to call us if you should have any questions or concerns. If you want to revoke this consent, you must do so in writing prior to your child's should mailed or given directly to us.
_____ Parent

_____ Parent
Signature is only valid for one year.
_____ Date

_____ Date

NOTE: Parent with whom the child lives should sign this form. If you are separated/divorced with a decree, which authorizes consent, or some special legal circumstances exist, please provide a copy of pertinent legal papers with this consent form.

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