NORTHWEST ASTHMA & ALLERGY CENTER

Authorization for Health Care of a Minor Child without a Parent or Legal Guardian Present

This form may be used to allow a minor child to receive treatment at our facility without a parent or legal guardian present. If the patient is 16 or over, s/he may come in by her/himself for recheck/sick appointments or allergen immunotherapy (allergy shots). The Authorization portion below would allow another adult to serve as a proxy decision maker for routine medical care and services. Routine medical care will not be provided to a minor without consent by the parent, legal guardian or authorized person(s) indicated below. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or emergent care being required

Child's Name: ____ Patient Date of Birth: __________________________
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AUTHORIZATION

I, the parent or legal guardian of the minor(s) listed above, hereby authorize the person(s) listed below to make health care decisions for my minor child(ren). I give permission to Northwest Asthma & Allergy Center to provide medical care and interventions which may include, but are not limited to: medical evaluation, physical exam, allergy skin testing, pulmonary function testing, any oral/intramuscular/intravenous medications, immunizations, allergen immunotherapy (allergy shots), x-rays, and lab work, pursuant to the consent of proxy or without proxy consent if medically necessary on an emergent basis, at the physician's discretion. I also agree for my minor child(ren) to have additional emergency care if warranted, to include utilization of 911 system, emergency room care and/or hospitalization.

I understand all co-pays must be paid at the time of service. I also understand whoever brings my minor child(ren) in will be expected to present valid identification and copies of insurance cards. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization.

Name: ____ Relationship: _________________________

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Name: ____ Relationship: _________________________

Name: ____ Relationship: _________________________

Name: ____ Relationship: _________________________

Name: ____ Relationship: _________________________

Limitations:

Identify any specific limitations on the kinds of medical services for which this authorization is given.
(If none, state "none").
☐ NONE

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Parental contact information for questions regarding treatment:

By checking the box(s) below next to the numbers listed, I give my permission for NW Ashtma & Allergy Center to leave detailed medical information at these numbers.

Name	Cell Phone #	Alternative Phone #
	☐	☐
	☐	☐

In the event an urgent or emergent medical situation arises that requires an immediate medical intervention (e.g. treatment of an allergic reaction to allergen immunotherapy [allergy shots]) and the parent, assigned proxy and/or legal guardian is not present, NAAC will treat the minor child as deemed necessary by our provider(s) and staff. We will contact the parent/legal guardian/proxy in a timely fashion to notify them of the clinical situation, the minor child's status, and intervention performed and rationale for the urgent medical intervention. This authorization is valid until the minor child's 18th birthday, unless revoked in writing by the undersigned, or a new form is completed. Only one parent signature is required.

Signature of Parent or Legal Guardian ______________________ Date ______________

Signature of Witness ______________________ Date ______________

Annual Updates

INITIALS______________ Date:______________ Reviewed and ☐ Changes made or ☐ Correct as is

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