Northwest Asthma & Allergy Center, P.S.

Authorization for Health Care of a Minor Child without a Parent or Legal Guardian Present for a Drug/Medication or Food Oral Challenge

I, the parent or legal guardian of the minor listed below, hereby authorize the person(s) also listed below

Name: _____ Relationship: _____

Name: _____Relationship: _____

to make health care decisions for my minor child while undergoing a Drug or Food Oral Challenge. 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, oral food challenge, lab work, x-rays, any oral/intramuscular/intravenous medications, 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 to have additional emergency medical 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 child 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.

I give my informed consent for my child to undergo an Oral Challenge to:

_____.

The purpose, risks, benefits and alternatives of an Oral Challenge procedure have been explained to my satisfaction. I understand that there is **always** a possibility of a reaction to a particular drug or food. I also understand that, as with every procedure, there is a possibility of unexpected complications. I authorize the doctors and staff of NW Asthma & Allergy Center to treat my child should an allergic reaction occur.

_____ Patient's Name	_____ Date of Birth
_____ Responsible Party/Guarantor Printed Name	_____ Relationship to Patient
_____ Responsible Party/Guarantor Printed Name	_____ Date
_____ Healthcare Provider's Signature	_____ Date