

# NORTHWEST ASTHMA & ALLERGY CENTER

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

Child's Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

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

### AUTHORIZATION

Please check applicable option below for authorization of treatment:

- I decline (non-emergency) treatment of my child if I am not present.
- I, the parent or legal guardian of the minor(s) listed above, authorize the patient who is 16 years or older to come in by her/himself for recheck/sick appointments and/or allergen immunotherapy (allergy shots).
- 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: \_\_\_\_\_

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:**

| Name | Cell Phone #             | Alternative Phone #      |
|------|--------------------------|--------------------------|
|      | <input type="checkbox"/> | <input type="checkbox"/> |
|      | <input type="checkbox"/> | <input type="checkbox"/> |

**By checking the box(es) next to the numbers listed above, I give my permission for NW Asthma & Allergy Center to leave detailed medical information at these telephone numbers.**

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 18<sup>th</sup> 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

**Annual Updates** (office staff to print, have patient review/make changes, initial and date annually)

INITIALS \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed and  Changes made or  Correct as is

INITIALS \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed and  Changes made or  Correct as is

INITIALS \_\_\_\_\_ Date: \_\_\_\_\_

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