NORTHWEST ASTHMA & ALLERGY CENTER

CONSENT TO TREAT A MINOR WITHOUT A PARENT/LEGAL GUARDIAN PRESENT FOR AN 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 an oral medication or food challenge. I permit 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 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, including utilization of the 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 medication 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.

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