THE ALLERGY AND ASTHMA CENTER
7222 ENGLE RD, FORT WAYNE, IN 46804 10415 LEO RD, FORT WAYNE, IN 46825
2280 PROVIDENT CT. #A, WARSAW, IN 46580
(260) 432-5005 — FAX: (260) 432-6003
www.AllergyAsthmaCenter.com

PROXY CONSENT TO TREAT MINORS FORM

The Allergy and Asthma Center requires a parent or legal guardian to be present at the new patient appointment. We feel it is also important for a parent of a minor child to attend all follow-up visits, but realize this may not be possible. This form may be used to allow an adult other than a parent to serve as a proxy decision maker for routine medical care and services at the Allergy and Asthma Center during recheck appointments.

For some families, it may be more convenient to have prior authorization in place that allows routine medical care to be delivered to minors under the care of a proxy decision maker if a parent or legal guardian cannot be present to provide consent. This is important, in that, medical care cannot be provided to a minor without approval by the parents or legal guardian, unless there is written consent. If you would like to appoint a proxy decision maker, please review and complete the following form authorizing a proxy decision maker to consent to and authorize medical treatment or services for and to be involved in the care of a minor child.

Authorization:

I hereby appoint: _____ _____
NAME RELATIONSHIP

As a proxy decision maker to consent to and authorize routine health care treatment and services for my child listed below. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, x-rays, lab work, allergy testing, pulmonary function testing. The Allergy and Asthma Center also may give limited immunizations, allergy shots, intramuscular/intravenous medications pursuant to the consent of the proxy.
I hereby empower and grant the proxy decision maker appointed above permission to consent to and authorize routine medical care as may be deemed necessary or advisable in the diagnosis and treatment of the minor child listed below and to receive protected health information directly relevant to, and for the purposes of, his or her involvement in this care or payment related to this care.

Child's Name: _____ DOB: _____

Limitations:

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

_____

_____

Parental contact information for questions regarding treatment:

Parent's Name: _____ Phone: _____

Alternative number:_____

Parent's Name: _____ Phone: _____

Alternative number:_____

The individual appointed as proxy (listed above) is permitted to make decisions or consent to the care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid until the above child's 18th birthday, unless withdrawn in writing to The Allergy and Asthma Center. Only one parent's signature is required.

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Signature of Witness Date

****Please send a list of current medications to each visit.**