ADVANCED
ALLERGY & ASTHMA
ASSOCIATES

Swapnil Vaidya, MD PhD
ALLERGY, ASTHMA & IMMUNOLOGY

Permission to Treat a Minor

Patient Name: _____ Date of Birth: _____
Last First MI

SSN: _____ Phone: _____

By signing below, you provide consent that your child may receive appropriate medical care and treatment, as deemed necessary by the providers at **Advanced Allergy & Asthma Associates**.

You authorize the following individual(s) to accompany your child at office visits –

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____
Signature of Parent/Guardian Date

_____ _____
Print Name Relationship to patient

www.fortworth-allergy.com
817-428-7000 (Phone) | 817-428-7006 (Fax)
5320 N. Tarrant Pkwy, Ste 220, Fort Worth, TX 76244