ADVANCED
ALLERGY & ASTHMA
ASSOCIATES

Swapnil Vaidya, MD PhD
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ALLERGY, ASTHMA & IMMUNOLOGY

Permission to Treat a Minor

Patient Name: _____ DOB: _____
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 also understand that a parent or legal guardian must be present in the building at all times in order for your child to receive treatment, testing, and/or injections.

You authorize the following individuals to accompany your child at office visits or injections:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____
Signature of Parent/Guardian: Date:

_____ _____
Print Name: Relationship to Patient: