ALLERGY, ASTHMA & IMMUNOLOGY CENTER, SC

325 Tamarack Lane / Shiloh, IL 62269 / (618) 624-2060 / Fax (618) 624-2226 / www.aaicenter.org / info@aaicenter.org

CONSENT TO TREAT MINORS FORM

The Allergy, Asthma & Immunology Center, SC (AAIC) 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 a minor patient to receive treatment at our facility without a legal guardian present or an adult other than a parent to serve as a proxy decision maker for routine medical care and services at the AAIC.

For some families, it may be more convenient to have prior authorization in place that allows routine medical care to be delivered to minors without their legal guardian present. This is important, in that, routine medical care will not be provided to a minor without approval by the parent 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

Proxy Contact (Phone/Cell): _____

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 AAIC also may give immunizations, allergy shots, any oral/intramuscular/intravenous medications pursuant to the consent of the proxy or without proxy consent if medically necessary on an emergent basis, at the physician's discretion.

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").

_____
_____

Allergy Immunotherapy without Legal Guardian/Parent/Proxy:

Does your minor patient to come to our office unaccompanied for allergy shots (immunotherapy)? Do you plan to leave your minor patient at our office for immunotherapy without proxy, legal guardian or parent present?

□ Please check this box if you consent to the AAIC administering allergy immunotherapy without proxy, legal guardian or parent being present.

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. In the event an urgent or emergent medical situation arises that requires an immediate medical intervention (e.g. treatment of an allergic reaction to allergy immunotherapy) and the parent, assigned proxy and/or legal guardian isn't present, the AAIC will treat the minor as deemed necessary by our physician(s) and staff. We will contact the parent/legal guardian/proxy in a timely fashion to notify them of the clinical situation, patient status and intervention performed and rationale for the urgent medical intervention. This authorization is valid until the above child's 18th birthday, unless withdrawn in writing to the AAIC. 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**