Allergy & Asthma Care of Florida | AllerVie HEALTH

Patient's Name:_____ DOB:_____

I, _____ guardian/parent of the above named patient of Allergy and Asthma Care of Florida allow my child, age 16 or over, to be evaluated and treated without my presence in the office. Treatment includes prescribing, where medically indicated, medicinal drugs needed by the minor child identified in this consent form.

I, _____ guardian/parent of the above named patient of Allergy and Asthma Care of Florida allow my child, age 16 or over, to receive immunotherapy without my presence in the office. If a reaction were to occur, the staff of Allergy & Asthma Care of Florida has my permission to render any necessary treatment, including the prescription, where medically indicated, of medicinal drugs needed by the minor child identified in this consent form.

I, _____ guardian/parent of the above named patient of Allergy and Asthma Care of Florida, authorize any of the following individuals:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a provider of Allergy and Asthma Care of Florida, including the prescription, where medically indicated, of medicinal drugs needed by the minor child identified below and we further agree to reimburse the health care provider for the cost of rendering these services.

If there are any questions, I can be contacted at _____.

_____ _____

Signature of Parent/Guardian Date

This consent is valid unless revoked in writing.

CONSENT FORM FOR TREATMENT OF MINOR CHILD

The State of Florida has enacted a new law that imposes additional obligations on health care providers when obtaining consent to treat a minor child. This form seeks to comply with our obligations under this new law, including obtaining a written consent to prescribe, where medically indicated, medicinal drugs needed by the minor child identified below. The new law also states that written consent must be obtained from a parent who has legal custody of the minor child or is the legal guardian of the minor child.

By signing below, I represent that I am either a parent with legal custody or the legal guardian of the minor child named below.

I give Allergy and Asthma Care of Florida physicians, other medical professionals, and employees, consent to provide, solicit and arrange for health care services, and prescribe medicinal drugs when necessary, to the minor child named below.

THIS CONSENT FORM HAS BEEN EXPLAINED TO ME AND MY QUESTIONS HAVE BEEN ANSWERED.

DATE: _____ TIME: _____ Signature: _____

Print Name: _____

Relationship: _____

Print Name of Minor Child: _____ Date of Birth: _____

If Interpretation is Used:

_____ Check: ☐ Phone ☐ Video

Qualified Staff / Interpreter Signature

_____

Print Qualified Staff / Interpreter Name ID Number Language Interpreted Date

PATIENT LABEL

OR

Patient / Minor Name _____

DOB _____

Patient ID _____

Allergy & Asthma Care of Florida

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