McKinney
Allergy and Asthma Center

2251 West Eldorado Parkway
Suite 150
McKinney, TX 75070

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CONSENT FOR TREATMENT OF MINOR CHILDREN

ACCOMPANIED BY AN ADULT OTHER THAN PARENT OR LEGAL GUARDIAN

I, _____, authorize McKinney Allergy and Asthma
(parent or legal guardian)

Center to treat _____ - _____
(child's name) (DOB)

for routine and emergency medical treatment when necessary by qualified medical personnel when accompanied by:

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

This authorization is valid for:

- ☐ Today's visit only
- ☐ From _____ (date) to _____(date)
- ☐ Until revoked in writing by me

This consent will be valid for (1) year from the date signed unless otherwise specified in writing.

_____
Printed name of parent/legal guardian

_____ _____
Signature of parent/legal guardian Date