

# TEXAS REGIONAL ASTHMA AND ALLERGY CENTER, L.L.P.

*Board Certified specialists in allergy, asthma, immunology, and respiratory disorders*

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## CONSENT TO TREAT MINOR

I hereby authorize Texas Regional Asthma & Allergy Center, L.L.P. to provide medical care to the patient below without a legal guardian present. Medical care may include a physical examination, certain diagnostic tests, allergy injections, medications by prescriptions, oral or injection.

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Legal Guardian's Name (print): \_\_\_\_\_

Parent/Legal Guardian's Signature: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

## VERBAL CONSENT TO TREAT MINOR

I \_\_\_\_\_ (Staff of TRAAC) spoke with \_\_\_\_\_

Legal Guardian for \_\_\_\_\_ over the phone and was given a verbal consent to treat.

\_\_\_\_\_  
Signature (Staff of TRAAC)

\_\_\_\_\_  
Date