Trinity Allergy, Asthma and Immunology Care, P.C.

3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801
1971 Highway 95, Bullhead City, AZ 86442 Tel. 928-758-6200
285 S. Lake Havasu Ave., Lake Havasu City, AZ 86403, Tel. 928-854-6800

Date:____________________________

Minor Patient Name:____

Date of Birth:_____________/__________/_______________ Age:______________

Patient's Home Address:____

____

Home Phone:_______________________________ Cell Phone:______________________________

Emergency Phone:____

I, ____, do hereby give permission and authorize Trinity Allergy/Dr. Natarajan Asokan to provide necessary medical care for my child, including but not limited to, evaluation, testing and treatment.

____

Signature of Parent/Guardian **Relationship** **Date**

The following named person(s) are permitted to bring my child named above to Trinity Allergy, Asthma and Immunology/Dr. Natarajan Asokan for medical care/testing/treatment(s).

1). _____________________________________ **other parent** ______________ Phone:_________________

2). _____________________________________Relationship _______________Phone:__________________

3). _____________________________________Relationship _______________Phone:__________________

4). _____________________________________Relationship ______________ Phone:__________________

____

Signature of Parent/Guardian **Relationship** **Date**

This consent is valid until I revoke it in writing.

Date:_______________________________Parent Signature:_____________________________________

Date:_______________________________Parent Signature:_____________________________________

Date:_______________________________Parent Signature:_____________________________________