Trinity Allergy, Asthma and Immunology Care, P.C.
3178 Western Ave #A, 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:_____