Praana
center for asthma & allergy

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DESIGNATION OF ANOTHER PERSON TO CONSENT FOR MEDICAL CARE

(minors only)

I, (parent/legal guardian)_____ , cannot accompany my child, (child's name)_____ , to **Praana Center for Asthma & Allergy.** Therefore, I give permission to (person's name; must be 18 years of age & older):

Individual 1: Name: _____

(Relation to child_____ Phone# :_____)

Individual 2: Name: _____

(Relation to child_____ Phone# :_____)

as follows (check ones that apply):

☐ I give permission for this person to accompany my child during their immunotherapy injection. I give consent for all medical treatment that may be required during this visit.

☐ I give permission for this person to accompany my child during their appointment with Dr.Koppula. I give consent for any procedures and/or medical treatment required during this visit.

Expiration of Permission: This form is VALID ONLY during the following timeframe (check one):
☐ Minor turns 18 years of age
☐ Effective date: _____ / Expiration date: _____

X_____ X_____
(Signature of parent or legal guardian) (Date)

Cell Phone _____ Home Phone_____

****IT IS YOUR RESPONSIBILITY TO INFORM OUR OFFICE IF A NEW INDIVIDUAL WILL BE ACCOMPANYING YOUR CHILD. IF THAT INDIVIDUAL IS NOT LISTED, WE CANNOT GIVE AN INJECTION NOR SEE YOUR CHILD FOR A VISIT***