CONSENT FOR NON-PARENT TO BRING IN MINOR

Name of Patient: _____ **Date of Birth**: _____

I _____ have the legal right to consent for someone other than
(Name of guardian)
myself to be an active participant in my child's medical treatment and act on my behalf in making health decisions as required.

I authorize the following individual(s), who is over 18 years of age:

1. Person being given
   Authorization: _____ Relationship to patient: _____
2. Person being given
   Authorization: _____ Relationship to patient: _____
3. Person being given
   Authorization: _____ Relationship to patient: _____
4. Person being given
   Authorization: _____ Relationship to patient: _____

To consent to medical care which is deemed necessary by the physicians and medical care providers at Kern Allergy Medical Clinic. Also, the ability to schedule and cancel appointments, request prescription refills, approve necessary course of action in the case of an anaphylactic reaction, and inquire about billing statements. I understand that this delegation includes receiving health information and my child which is essential to make immediate necessary health care decisions.

This consent is valid indefinitely or until revoked in writing by me, the parent.

_____ _____ _____

Signature of Parent **Printed Name** **Date**

Contact information for parent:

Phone number: 1._____ 2. _____

Email(optional): _____