PARTNERS IN ALLERGY AND ASTHMA CARE, LLC ***DIV. FLORIDA PEDIATRIC ASSOCIATES, LLC***

ALAN B. HALSEY, MD
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BOARD CERTIFIED ALLERGISTS/IMMUNOLOGISTS
KATHLEEN G. LIKAR, ARNP
ALLERGY-IMMUNOLOGY NURSE PRACTITIONER

I, _____ give permission for

_____

_____

to accompany my child _____

to physician or other healthcare provider's facility, and to approve any necessary treatment the physician or other provider may recommend.

I, _____ as the parent or responsible party, understand that any charges incurred during the visit will be my responsibility.

_____
Signature

_____
Print Name

_____
Child's Name and Date of Birth

_____
Date Signed

_____
Witness