PARTNERS IN ALLERGY AND ASTHMA CARE, PA **813-681-6537**

Welcome to Partners in Allergy & Asthma Care! Thank you for allowing us to participate in your child's healthcare needs. Please print out this form, fill in the required information, and bring the form with you to your child's first appointment. This will help ensure a thorough evaluation.

CHILD'S NAME:_____ DOB:_____

PARENT/LEGAL GUARDIAN
NAME:_____

PARENT/LEGAL GUARDIAN
SIGNATURE:_____
(This must be the same as the name entered above.)

CHILD'S PEDIATRICIAN/PCP:_____

CURRENT MEDICATIONS:_____

_____

REASON FOR VISIT:_____

Other person(s) authorized to bring my child to Partners in Allergy & Asthma Care. (Please indicate with a YES or NO if those persons are authorized to give such permission in your absence. **PLEASE NOTE: If the provider orders treatment, testing, etc., our office will make every attempt to contact you personally to obtain your permission before proceeding.)**

_____ _____ YES / NO
(Name) (Relationship to child)

_____ _____ YES / NO
(Name) (Relationship to child)

_____ _____ YES / NO
(Name) (Relationship to child)

IMPORTANT: Please provide your emergency contact information below: (i.e. cell phone, work phone, etc.)

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