21730 South Vermont Avenue, Suite 131
Torrance, California 90502
ph: (310) 606-3877
fax: (310) 694-8007
www.accesahealth.com

Authorization to Treat a Minor

I ____________________________ (parent's name) hereby authorize the following person to give their consent for health care treatment to be administered by medical providers at Accesa Health to my minor child ____________________________ (minor's name) until ____________________________ (date you wish this authorization to expire, state "no expiration" if desired).

Representative: ____________________________ Relationship: ___________________________

I am aware that Accesa Health medical providers diagnose and treat common illnesses, prescribe medications, recommend over the counter medications, provide health screening and diagnostic testing and administer vaccinations, among other services.

I have listed any known allergies my child has in the space below.

Known Allergies (including medications, dye, latex, eggs, etc.)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Signature of Parent: ____________________________

Relationship to Minor: ____________________________

Date: ____________________________