

**RICHARD R. ROSENTHAL, M.D., LTD.**

Adult and Pediatric Allergic Disease, Asthma and Immunology

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**AUTHORIZATON FORM FOR UNATTENDED MINORS**

I am requesting that Richard R. Rosenthal, M.D., Ana M. Saavedra-Delgado, M.D., Richard A. Nicklas, M.D. and Natalie E. Arias, F.N.P. give treatment to my son/daughter \_\_\_\_\_, when I am not present in the office. I understand that treatment may include medical care, allergy injections, or be given medication samples or written prescriptions as needed. If this request is approved I authorize Richard R. Rosenthal, M.D., Ana M. Saavedra-Delgado, M.D., Richard A. Nicklas, M.D. and Natalie E. Arias, F.N.P. . to give treatment to my son/daughter \_\_\_\_\_, when I am not present in the office. He/she may receive medical care, allergy injections, or be given medication samples or written prescriptions as needed.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian (Print)

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

Phone Numbers where Parent/Legal Guardian may be reached in the event of an emergency:

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

***For office use only:***

This request has been reviewed by the responsible provider:

Request Approved       Request Denied

Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Responsible Provider (Printed Name)

\_\_\_\_\_  
Signature Responsible Provider

\_\_\_\_\_  
Date

Parent/Legal Guardian notified on \_\_\_\_\_ (Date) by \_\_\_\_\_