THE ALLERGY AND ASTHMA CLINIC

ANDREW C. ENGLER, M.D. *BROOKE LEON, N.P.*

CONSENT
TREATMENT OF A MINOR

I acknowledge that in order for THE ALLERGY AND ASTHMA CLINIC to administer treatment or any allergy shots to my child in my absence, I must give written permission. I understand that it will not be possible to treat my child in my absence without this written consent.

Therefore, I hereby give permission to THE ALLERGY AND ASTHMA CLINIC to administer allergy injections and appropriate treatment to my child

_____, in my absence.

Date of Birth:_____/_____/_____
Month Day Year

Today's Date: _____

Signature of Patient/Guardian:_____

Signature of Witness: _____

Medical Record Number: _____

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