THE ALLERGY AND ASTHMA CLINIC
ANDREW C. ENGLER, M.D. *JUNE Y. ZHANG, M.D.*
BROOKE LEON, N.P. *ELISABETH DENKER, N.P.*

CONSENT TO TREATMENT OF A MINOR

I acknowledge that in order for THE ALLERGY AND ASTHMA CLINIC to evaluate, administer treatment or administer 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 evaluate, administer treatment, as well as administer allergy shots 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: _____

290 Baldwin Avenue San Mateo, CA 94401
Ph: (650)343-4597 Fax: (650)343-3402
www.theallergyclinic.com