## THE ALLERGY AND ASTHMA CLINIC

ANDREW C. ENGLER, M.D. BROOKE LEON, N.P. ELISABETH DENKER, N.P.

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## **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 W	itness:			
Medical Recor	d Number:			