



Allergy and Asthma Associates, P.C.

Sharon Seth, MD

Courtney J. Blair, MD

Bridget Schaefer, PA-C

**AUTHORIZATION FOR A MINOR PATIENT TO RECEIVE TREATMENT IN THE
ABSENCE OF A PARENT/LEGAL GUARDIAN**

I am the parent/legal guardian of the child listed below (collectively "my child") . There are no court orders currently in effect which would prohibit me from exercising the power that I now seek to convey.

As the parent/legal guardian of the below name minor patient, I hereby give consent for my child to be treated by the physicians at Allergy and Asthma Associates, in my absence. I authorize the adult listed below to authorize any necessary treatment and/or sign any registration and insurance materials. This treatment can include routine medical care, allergy injections, special testing and any emergency medical treatment deemed to be necessary whether such emergency treatment is administered in the office of Dr. Blair, Dr. Seth, and/or Bridget Schaefer, PA, or at a designated hospital. Authorization is also given to request the services of an ambulance at the expense of the parent/legal guardian should such transportation to the hospital be deemed necessary by Dr. Blair, Dr.Seth, and/or Bridget Schaefer, PA or their staff.

With regards to allergy injections and/or testing, I understand that, while generally recognized as safe, allergy injections and/or testing may cause local reactions in the form of swelling and tenderness at the injection or testing site. I further understand that, in rare cases, severe systemic reactions such as hives, swelling, asthma and shock may develop after allergy injections or any testing. While unusual, the latter may be life threatening and may require immediate emergency treatment. In an effort to provide safe care regarding potential injection reactions, patients are required to remain in the office for an assessment period of thirty minutes after allergy injections. This agreement shall remain in effect until the child reaches the age of 18 or revoked by the parent.

Minor Patient's Name (Please Print): _____

Patient's Date of Birth: _____ Phone Number: _____

Parent/Legal Guardian's Name (Please Print): _____

☐ **I hereby designate the individual on the following list to act on my behalf when I am not reasonably available to provide consent necessary for the health care of my child.**

Name: _____ Phone: _____

Relationship to child: _____ *Address: _____

☐ **My child will be coming to Allergy and Asthma Associates ALONE (if over the age of 16, for AIT ONLY).**

YOU MUST PROVIDE OUR OFFICE WITH A PHONE NUMBER WHERE YOU CAN BE REACHED IN AN EMERGENCY

■ Home: (_____) _____ ■ Work: (_____) _____ ■ Mobile

(_____) _____

(Address): _____

(Parent/Legal Guardian Signature) _____ (Printed Name): _____

(Witness Signature / Name): _____ (Date): _____