A&A **Allergy & Asthma**
of Southern Indiana, P.C.

Consent for Treatment of a Minor Without a Parent or Legal Guardian Present

Patient Name:_____ Date:_____

Patient Date of Birth:_____

Minors under age 16 unaccompanied by a parent or legal guardian:

_____I understand that it is the policy of Allergy & Asthma that minors under the age of 16 are to be accompanied to office visits or allergy shots by a responsible adult. If I am unable to accompany my child, I give permission for the following person / people to bring them instead:

_____ _____

_____ _____

Minors age 16 or older:

_____ I authorize the staff of Allergy & Asthma of Southern Indiana to treat the above named minor for an office visit and / or shots without my presence or the presence of another accompanying adult in the building.

ALLERGY SHOTS (Consent for treatment):

_____ In the event that I am unable to **personally** accompany my child to Allergy & Asthma of Southern Indiana for their allergy / venom shots, I give my permission for the shots to be administered without my presence and also any treatment that might need to be given due to complications or adverse reactions that could occur from receiving the shots.

_____ _____

Printed Name of Parent / Legal Guardian **Signature of Parent / Legal Guardian**

_____ _____

Witness Signature **Date**