Allergy & Asthma Center of NW Florida, P.A.
Thomas G. Westbrook, M.D.
6160 North Davis Highway, Suite 3 Telephone: (850) 473-1121
Pensacola, Florida 32504 Fax: (850) 473-1122

Consent to Treat Minor Child Without Guardian Present

Patient Name: _____ **DOB:** _____
(Please Print)

Parent Name: _____
(Please Print)

I give permission for my child to receive medical care, without parental presence, at the Allergy & Asthma Center of Northwest Florida, P.A. This care is to include: Office visits, skin testing, and Immunotherapy injections. It may also include any treatment deemed necessary for emergency care.

I also give permission for the following people to accompany my child to the Allergy & Asthma Center of Northwest Florida, P.A. for treatment.

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

In the event of an emergency, I can be reached at the following numbers:

Home: _____ Work: _____ from _____ to _____

Cell: _____ Pager: _____

Emergency contact, in the event I cannot be reached at the above listed numbers.

Contact Name: _____

Relationship: _____ Phone: _____

_____ _____
Signature of Parent or Guardian Date