St. Paul Allergy & Asthma

AUTHORIZATION TO TREAT MINORS UNACCOMPANIED BY PARENT OR LEGAL GUARDIAN

PATIENT NAME: _____ DOB: _____

St. Paul Allergy & Asthma Clinic, PA has my permission to give medical care in my absence. Medical care may include periodic examinations, consultation and/or treatment, including allergy injections.

NOTE: MINORS UNDER AGE 12 MUST HAVE A RESPONSIBLE PARTY AGE 16 OR OLDER PRESENT FOR ANY FORM OF CARE.

PATIENTS MUST WAIT IN THE OFFICE FOR 30 MINUTES AFTER ALLERGY INJECTIONS

SIGNED: _____ PRINTED NAME: _____

RELATIONSHIP TO PATIENT: _____ DATE: _____