

# DallasAllergyImmunology

## PERMISSION TO TREAT MINOR

You and your child's physician have discussed a proposed course of treatment for

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(Name of Child)

You have indicated, and your doctor concurs, that you wish your child to assume the limited responsibility of coming to our office for their treatment unaccompanied.

Accordingly, we ask you to indicate by signing below that we have your consent to administer to your child the following on an ongoing basis (initial all that apply):

- \_\_\_\_\_ series of allergy shots
- \_\_\_\_\_ examinations
- \_\_\_\_\_ pulmonary function tests (pft)
- \_\_\_\_\_ blood draws
- \_\_\_\_\_ immunizations (flu shot)
- \_\_\_\_\_ breathing treatment(s)
- \_\_\_\_\_ emergency treatment of allergic reaction or asthma
- \_\_\_\_\_ other \_\_\_\_\_

You are acknowledging by your signature that the risks, benefits, and alternatives to the treatment(s) or examinations checked above have been explained to you (including the alternative of no treatment or examination); that you have had the opportunity to ask questions; that your questions have been answered; and that you agree to pay for these examinations or treatments.

Please call us if you have any questions or concerns. If you want to revoke consent, you must revoke this consent in writing prior to your child's scheduled appointment: this should be mailed or given directly to us.

\_\_\_\_\_  
Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent

\_\_\_\_\_  
Date

*Signature is only valid for one year.*

NOTE: Parent with whom the child lives should sign this form. If you are separated/divorced with a decree, which authorizes consent, or some special legal circumstances exist, please provide a copy of pertinent legal papers with this consent form.