Patient's Name:_____ DOB:_____

I, _____ guardian/parent of the above named patient of Allergy and Asthma Care of Florida allow my child, age 16 or over, to be evaluated and treated without my presence in the office. Treatment includes prescribing, where medically indicated, medicinal drugs needed by the minor child identified in this consent form.

I, _____ guardian/parent of the above named patient of Allergy and Asthma Care of Florida allow my child, age 16 or over, to receive immunotherapy without my presence in the office. If a reaction were to occur, the staff of Allergy & Asthma Care of Florida has my permission to render any necessary treatment, including the prescription, where medically indicated, of medicinal drugs needed by the minor child identified in this consent form.

I, _____ guardian/parent of the above named patient of Allergy and Asthma Care of Florida, authorize any of the following individuals:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a provider of Allergy and Asthma Care of Florida, including the prescription, where medically indicated, of medicinal drugs needed by the minor child identified below and we further agree to reimburse the health care provider for the cost of rendering these services.

If there are any questions, I can be contacted at _____.

_____ _____

Signature of Parent/Guardian Date

This consent is valid unless revoked in writing.