Allergy & Asthma Associates of Allen

Consent to Medical Treatment of a Minor

To Whom It May Concern:

I hereby give permission for Allergy & Asthma Associates of Allen to examine and treat my child,

_____ is _____ years of age.
Patient's Name

- Guardian Name: _____ Relationship: _____

  Cell Number: _____

- Guardian Name: _____ Relationship: _____

  Cell Number: _____

- Individual over the age of 16 **AUTHORIZED** to bring the patient for injections:

  Name: _____ Relationship: _____

  Cell Number: _____

I further give my permission and consent to the physicians, nurses, and staff of Allergy & Asthma Associates of Allen to administer any medical treatment sought by me on the minor's behalf.

Date: _____

Signature: _____

Witness: _____

Relationship to Minor

- Mother
- Father
- Guardian

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