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PERMISSION FOR MEDICAL CARE/ALLERGY INJECTIONS

I give permission for _____ (my son/daughter/dependent) to receive **medical care, allergy injections and emergency medical care** at Allergy & Asthma Care, P.A. in my absence.

Signed _____ Date _____
(parent/guardian)

Contact Numbers: Home: _____ Cell: _____ Other: _____

Witnessed _____

The following individuals may accompany my child and may share protected health information:

<i>Name</i>	<i>Relationship</i>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

The above authorization is in effect until Allergy & Asthma Care, P.A. is notified of its revocation in writing.