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PERMISSION FORM 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 ______________________________________
(parent/guardian)

Date ______________________________________

Phone/Contact/Cell # _________________________

Witnessed ___________________________________

****

The following individuals (must be at least 18 years old) may accompany my child and may share protected health information:

Name	*Relationship*

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

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