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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.