FAMILY ALLERGY & ASTHMA CONSULTANTS
Sudhir Prabhu, MD Sunil Joshi, MD Hary Katz, MD
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(904) 636-9100

CONSENT TO TREAT A MINOR WITHOUT A PARENT PRESENT

To: Family Allergy & Asthma Consultants

You are hereby authorized to treat _____ , a minor child, for allergy injections and/or treatment in my absence. I understand that my minor child named above will be required to remain in your office 30 minutes after an allergy injection to monitor for any adverse reactions.

I hereby release Family Allergy & Asthma Consultants and its medical staff, employees and agents from any liability for adverse effects to me or my minor child which results from my absence.

_____
Print Patient's Name

_____ _____
Signature of Parent or legal guardian DATE