FAMILY ALLERGY & ASTHMA CONSULTANTS
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CONSENT TO EVALUATE, TEST AND/OR TREAT A MINOR WITHOUT A PARENT PRESENT

To: Family Allergy & Asthma Consultants

I hereby authorize _____ to bring in _____, my minor child, for evaluation, testing and/or treatment.
Patient's Name

I also hereby authorize Family Allergy & Asthma Consultants (FAAC) to evaluate, test and/or treat _____ without my being present, if brought in by the above named individual.

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.

_____ _____
Signature of Parent or legal guardian DATE

_____ _____
Witness – Printed Name Witness' Signature