# SouthCoast Allergy, P.A.

## Authorization to designate another party to accompany

**If the patient is a minor and you would like to designate another party to accompany the child to an office visit, an allergy injection, etc., please complete the section below:**

I consent and authorize _____ to also consent to and authorize evaluation and treatment for my child, _____, DOB _____, when I am not available. I understand that authorizes the person(s) named above to consent to medical services and procedures for the child named above. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____

Parent Signature Date

## Consent to Treat in Relation to Minors

**If the patient is a minor and you would like to give permission for the child to receive allergy services and procedures (including allergy injections and treatment for a severe reaction) on his/her own without the accompany of a parent or guardian, please complete the section below:**

I consent and authorize my child, _____, DOB _____, to receive allergy services, procedures, and treatment without the supervision of his/her parent(s) or guardian. This consent allows the child to receive allergy services and procedures which includes allergy injections and treatment for a severe reaction. As the child's parent or guardian, I assume full responsibility for any charges incurred. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____

Parent Signature Date