Allergy Asthma & Sinus Center, P.C.

Board Certified in Allergy and Immunology

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Tuomey Medical Center
100 N. Sumter Street
Suite 405
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803-934-1488
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Consent for Treatment of a Minor

Without a Parent or Legal Guardian Present

Date: _____

Patient Name: _____

Patient Date of Birth: _____

Minors under age 16:

_____I understand that it is the policy of Allergy, Asthma & Sinus Center, P.C. that **minors under the age of 16 are to be accompanied** to office visits or allergy shots **by a responsible adult**. If I am unable to accompany my child, I give permission for the following person /people to bring them instead:

_____ _____
Relationship to patient

_____ _____
Relationship to patient

_____ _____
Relationship to patient

Minors age 16 or older:

ALLERGY SHOTS (Consent for treatment):

_____ In the event that I am unable to **personally** accompany my above-named minor child to Allergy, Asthma & Sinus Center, P.C for their allergy shots, I give my permission for my child to travel on an unaccompanied basis to the office of Allergy, Asthma & Sinus Center, P.C for the allergy shots to be administered without my presence and also any treatment that might need to be given due to complications or adverse reactions that could occur from receiving the shots.

This also confirms that I have read and understand the allergy shot consent form (copy available upon request); have reviewed the consent with my child and have emphasized to my child the need to wait 30 minutes after the shot.

_____ _____
Printed Name of Parent / Legal Guardian **Signature of Parent / Legal Guardian**

_____ _____
Witness Signature **Date**