ALLERGY PARTNERS
Leaders in Allergy & Asthma Care www.allergypartners.com

Allergy Partners of the Shenandoah Valley
1828 Plaza Drive Winchester, VA 22601
5406629115 Fax: 5406650411

Consent for Medical Treatment of a Minor

For:
DOB:

I am the parent or legal guardian of the minor child listed above and have consented to the treatment of the child by Allergy Partners. I understand that the providers or staff of Allergy Partners recommend having a parent or guardian present during office visits and/or allergy immunotherapy injections. However, there may be times when a parent/guardian is unavailable. Therefore, I consent to the following. Please initial all that are applicable:

1. I am the parent or legal guardian of a minor child who is aged 16 years old or older. I hereby give my consent for the medical treatment of my child, including appointments with the physician, without the presence of an adult, parent or legal guardian.

2. I am the parent or legal guardian of a minor child who is aged 16 years old or older. I hereby give my consent for my child to receive allergy immunotherapy injections without the presence of an adult, parent, or legal guardian. I understand and agree that it is important that my child wait at least 30 minutes after receiving an allergy injection and communicate any potential shot reactions to the staff. I understand and agree that if my child does not wait 30 minutes after receiving an injection that Allergy Partners may discontinue providing allergy immunotherapy without an adult present. In the event an urgent or emergent medical situation arises that requires an immediate medical intervention (e.g. treatment of an allergic reaction to allergy immunotherapy) and I am not present, I understand Allergy Partners will treat the minor as deemed necessary by our physician(s) and staff. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization.

3. I authorize the individuals listed below

Name of Agent	Relationship to Child
_____	_____
_____	_____
_____	_____

to consent to any medical evaluation and/or treatment, diagnosis or care which is deemed advisable by physician. It is understood that this authorization is given to provide authority and power on the part of those listed above to give specific consent to any and all such evaluation, diagnosis, office treatment which a physician, in the exercise of his/her best judgment, may deem advisable. This authorization also grants to those listed above the power to sign for release of information to any third-party payers who may be responsible for part or all of the cost of the services provided.

Expiration of Consent: This Consent will be in effect until specifically terminated or modified by written notice or until the date the minor becomes an adult under state law.

_____	_____
Patient's Name (please print)	Patient's Date of Birth
_____	_____
Parent's/Guardian's Signature	Date
_____	_____
Parent's/Guardian's Signature	Date