ENT & ALLERGY OF DELAWARE | COMPLETE CARE.

302.998.0300
www.entad.org

Consent for Treatment of a Minor
Without a Parent or Guardian Present

Patient Name: _____ Date: _____

Patient Date of Birth: _____

Allergy Shots for Minor Age 16 or Older:

In the event that I am unable to **personally** accompany my above-named minor child age 16 or older to ENT & Allergy of Delaware for his/her allergy shots, I authorize the staff of ENT & Allergy of Delaware to administer my child's allergy shots and also provide any treatment that might need to be given due to complications or adverse reactions that occur from my child receiving his/her allergy shots.

This confirms that I am aware of and have given permission for my child to travel on an unaccompanied basis to the offices of ENT & Allergy of Delaware for purposes of receiving his or her allergy shot and any related care or treatment.

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 or Guardian Signature of Parent or Guardian

Date: _____