COMPLETE CARE.

302.998.0300
www.entad.org

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

______________________________ **Patient Name**

__________________ **Patient Date of Birth**

__________________ **Today's Date**

In the event that I am unable to personally accompany my minor child **(age 16 or older)** to ENT & Allergy of Delaware for their allergy shots, I authorize the staff of ENT & Allergy of Delaware to administer my child's allergy shots as well as 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 treatment includes but is not limited to: administration of adrenalin (epinephrine), antihistamines, IV solutions, resuscitation equipment and other materials necessary to treat anaphylactic reactions.

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 their allergy shot and any related care or treatment.

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.

______________________________ Signature of Parent or Guardian

__________________ Date

______________________________ Printed Name of Parent or Guardian

______________________________ Emergency Contact and Phone Number

__________________ Relationship to Patient

______________________________ Emergency Contact and Phone Number

__________________ Relationship to Patient