FAMILY
Allergy & Asthma

PARENTAL CONSENT FORM

Consent for Children 16 – 17 to receive allergy shots

without a parent or legal guardian present

Minor Immunotherapy Visit Authorization (No Parent/Guardian Present)
I am the parent or legal guardian of the minor identified below. I authorize Family Allergy & Asthma ("FAA") to administer my child's prescribed allergy immunotherapy injections during visits when I am not present. I confirm my child is permitted to present for the appointment and to follow FAA's instructions and clinic policies, including any required post-injection observation period. I agree to remain reachable by phone during the visit and to promptly pick up my child if requested. This authorization remains effective until revoked by me in writing.

Mandatory Wait Time and Symptoms

Family Allergy and Asthma is committed to providing safe and effective treatment for patients. Therefore, **we require waiting 30 minutes after receiving allergy injections** to ensure an allergic reaction does not occur. Allergic reactions can range from mild local reactions to more severe generalized reactions, including hives and even death. These symptoms may consist of any of the following: itchy eyes, nose or throat; nasal congestion; runny nose; tightness in throat or chest; coughing; increased wheezing; lightheadedness; faintness; nausea; hives; generalized itching; or other symptoms. Report these or any other symptoms to the nurse immediately so appropriate action may be taken. Although it is rare to have a severe allergic reaction to any allergy shot, it can occur even after taking allergy shots for years. We take many precautions to minimize any potential risks. Research has shown that if a severe reaction is to occur, symptoms usually begin within 30 minutes of receiving the injection.

In signing this consent, I acknowledge that I have read and understood Family Allergy and Asthma's mandate to wait 30 minutes.

Acknowledgment and Assumption of Risk
I understand that allergy immunotherapy can cause reactions, including local reactions and, rarely, serious systemic reactions such as anaphylaxis that may require emergency

treatment. I have had the opportunity to ask questions, and I consent to treatment with this understanding. I authorize FAA to provide reasonable and necessary care in response to a reaction, including administration of emergency medications and contacting emergency medical services when clinically indicated.

I acknowledge that my child cannot attend the first allergy injection appointment alone, nor any other appointments outside of routine shot appointments.

I am allowing my child,

_____, to receive his/her allergy injections without a parent or legal guardian present.

Patient Name (please print) _____	Date of birth _____
Parent/Legal Guardian Name (please print) _____	Date _____
Signature _____	Contact Number (for emergency use) _____
Patient Account Number (clinic use only) _____	