Allergy & Asthma Associates of Allen

Hari Reddy, D. O., FAAAAI, FACAAAI
Board Certified in Adult and Pediatric Allergy and Immunology
977 Raintree Circle, Ste 100
Allen, TX 75013
972-747-7007

Consent to Medical Treatment of a Minor

To Whom It May Concern:
I hereby give permission for Allergy & Asthma Associates of Allen to examine and treat

my child, _________________________________is __________________years of age.
Patient's Name

Parents &/or Guardian of Minor	Name	Relationship	Telephone Numbers
Parent/Guardian	______________________		Home: ____________ Cell: _____________
Parent/Guardian	______________________		Home: ____________ Cell: _____________
Individuals over the age of 16 authorized to bring the patient for injections	_______________________		Home: ____________ Cell: _____________

I further give my permission and consent to the physicians, nurses, and staff of Allergy & Asthma Associates to administer any medical treatment sought by me on the minor's be half

Signed this _________ day of ___________________, 20_____.

____
Signature

Relationship to Minor
□ Mother □ Father □ Guardian

____
Witness