SHORELINE ALLERGY & ASTHMA ASSOCIATES, LLP

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CONSENT FOR 16/17 YEAR OLD TO BE EXAMINED, TREATED, SKIN TESTED OR TO BE GIVEN AN ALLERGY INJECTION WITHOUT A PARENT/GUARDIAN PRESENT

Skin testing, allergy injections and immunotherapy should be administered at a medical facility under the supervision of a physician since occasional reactions may require immediate therapy. These reactions may consist of any of the following symptoms: itchy eyes, nose, or throat, nasal congestion, runny nose, tightness in the throat or chest, coughing, increased wheezing, lightheadedness, faintness, nausea, vomiting, hives, generalized itching, shock. Reactions, even though unusual, can be serious but rarely fatal. The skin testing /injection procedure has been explained to me and the opportunity has been provided for me to ask questions regarding potential side effects. I understand that every precaution consistent with the best medical practice will be carried out to protect my child against such reactions.

For patients receiving allergy injections: I have read (if new patient) or re-read (if established) the patient information sheet on immunotherapy and understand the risks and benefits. I understand that my child must wait in the medical facility for at least 30 minutes after each injection.

In the event a reaction requiring medication or treatment occurs in my absence, I give permission for such treatment to be administered to my child.

I also give permission for any necessary examination or treatment to be administered to my child in my absence.

Patient's Name: _____

Parent (or legal guardian): _____Date: _____

Emergency Contact: _____

Phone numbers:

Home # _____ Work # _____Cell # _____