ALLERGY ASTHMA CLINIC, LTD **CONSENT FOR TREATMENT OF A MINOR**

I do hereby give permission for _____ to be treated by the physicians and staff members at Allergy Asthma Clinic, LTD.

In my absence, this minor may be evaluated in the clinical setting (office visit), receive allergy injections, Xolair/Nucala/Fasenra injections, and complete testing as deemed medically appropriate. In my absence, I give permission for this child to be promptly treated for any reaction or emergency by any of the clinicians available (Bart Leyko, M.D., Dr.Christopher Couch, M.D. or Sherri Crespin, F-NP).

I, the undersigned, certify that all procedures (including the risks) have been thoroughly explained to me. Additionally, I was provided the opportunity to ask questions and those questions have been addressed.

_____ _____

PARENT/GUAURDIAN SIGNATURE Date

_____ _____

RELATIONSHIP TO PATIENT CONTACT PHONE NUMBER