



CONSENT TO ALLERGY TREATMENT FOR UNACCOMPANIED MINOR

To: **Big Lake Clinic**

Patient Name: _____

Patient's Date of Birth: ____/____/____

I hereby authorize the doctors of Big Lake Clinic, and such assistants as the doctors may designate, to administer allergy treatments to the above-named minor at such intervals as are necessary for the minor's health and best interests. The treatments may be administered whether or not such minor is alone or accompanied by me or another adult.

In case the minor experiences a reaction to the **authorized allergy treatments**, I understand that you will make every effort reasonable under the circumstance to notify me of the situation and obtain my preferences. If such efforts to contact me are unsuccessful, or if the situation requires action without delay, I hereby authorize the above-named personnel to take such action medically necessary for the care and treatment of the minor.

I understand that this consent will last for one year unless I change my mind and withdraw my consent sooner in writing. If I withdraw consent, it will not affect actions already taken by the Big Lake Clinic.

Date: ____/____/____

Person who is granting authority to consent (please print): _____

Signature of person who is granting authority to consent: _____

Relationship to named minor: _____