



The Austin Diagnostic Clinic
Allergy & Immunology Department
Offices in North Austin, South Austin
and Round Rock

Office: (512) 901-4002
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Appointments: (512) 901-4002
www.adclinic.com/allergy

Consent for Treatment of a Minor

Certification of Disclosure of a Physician

I have been given an opportunity to ask questions about my child's condition, alternative forms of treatment, risk of non-treatment, the procedures to be used, and the risks and hazards involved and I believe that I have sufficient information to give this informed consent. I understand that no warranty or guarantee has been made to me as to result or cure.

I do hereby give consent for _____ to be given allergy shots over an extended period of time and at specified intervals as prescribed by a physician in the allergy section of The Austin Diagnostic Clinic without my physical presence on the premises.

I voluntarily request Dr. _____ as my child's physician, and such associates, technical assistants, and other health care providers as they deem necessary, to treat my child's condition which has been explained to me.

I understand that, although rare, severe systemic reactions may result in permanent disability or even death.

I consent and authorize the treatment of any reactions that may occur as a result of an allergy shot.

I have read the above allergy shot rules and agree to follow them.

I, the undersigned, certify that the procedures and treatments involved in this consent have been explained in detail and I authorize said treatment, including administration of injections and treatment of any reactions which may occur in my absence.

Parent/Guardian

Relationship