Iowa Allergy, Asthma, & Immunology P.C.

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Consent to Treat a Minor Without a Parent or Legal Guardian

Patient's Name_____ D.O.B_____

Iowa Allergy must receive permission, from a child's parent or legal guardian, prior to providing treatment(s) and/or care. Treatment may include but not limited to allergy shots, office visits, skin testing, and/or lab work, and treatment for anaphylaxis as deemed necessary by a physician. **In the event that an adult or legal guardian is not present**, this form provides the legal permission to treat without any adult present for the listed procedures.

This authorization shall remain effective until otherwise revoked by the patient and/or parent/guardian in writing. I understand that it is my responsibility to update the above information if I want it changed. However, I may be asked to confirm the information with a new dated signature on an annual basis unless I revoke this consent in writing.

Iowa Code Chapter 599 indicates a minor must have consent signed in order for the minor to receive medical treatment. I understand that by refusing to sign or if I revoke this consent, Iowa Allergy will refuse to treat my minor child.

I fully understand and **accept** the terms of this consent.

_____ _____

Parent/Legal Guardian name (Print) Date

_____

Parent/Legal Guardian Signature