Allergy & Asthma Specialists, P.S.C.

Lee S. Clore, Jr., MD - Board Certified Allergy/Immunology
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I, _____ (Parent/Legal Guardian) of _____ (City & State) do hereby state that I am the parent or legal guardian of _____ (Patient/Child's Name) a minor born ___/___/_____ (mm/dd/yyyy) who resides with me at _____ (Street Address). I hereby give my permission and written consent to _____ (Person Accompanying Child) to receive medical information and to make medical decisions on behalf of the above-named child or render any and all medical and/or surgical treatment to the above-named child deemed necessary in connection with an injury or illness in my absence from the medical office of Allergy & Asthma Specialists, P.S.C. This consent is effective from ___/___/_____ (mm/dd/yyyy) until I terminate this consent in writing and give to Allergy & Asthma Specialists, P.S.C.

Signature: _____ Date: _____
(Parent named above)

Witness (must not be parent, guardians, or children listed above):

Signature: _____ Date: _____