# CONSENT TO ALLERGY TREATMENTS FOR UNACCOMPANIED MINOR

**Patient Name:** _____

**DOB:** _____

**Medical Record #:** _____

I hereby authorize the providers of CCM Health and such assistants as the providers 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, accompanied by another adult, or myself.

In case the minor experiences a reaction to the authorized allergy treatments, I understand that you will make every effort reasonable under the circumstances 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 authorize the above named CCM Health personnel to take such action as is medically necessary on the minor's behalf.

I understand that this consent will last for one year, unless I withdraw consent sooner in writing. If I withdraw consent, it will not affect actions already taken by CCM Health.

_____ _____

**Signature of Parent or Guardian Authorizing Treatment** **Date/Time**

_____

**Relationship to Minor**