Allergy & Asthma Center of East Orlando

Boyce A. Hornberger, M.D, FAAAAI
Diplomate American Board of Allergy and Immunology

To: Allergy & Asthma Center of East Orlando
Re: Authorization to Treat

Patient: _____ DOB: _____

I, _____ (parent) give my permission for _____ (patient's name) to receive allergy injections without a parent in attendance.

If there should be any allergic reaction, I give Allergy & Asthma Center permission to treat my child medically for this reaction. If medically necessary, I request that he / she be transported to the nearest hospital emergency room.

In case of an emergency, I can be reached at_____

_____ Date _____
Parent's Signature

_____
Parent's Name (print)

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