



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 _____

Parent's Signature Date _____

Parent's Name (print)