PIEDMONT PEDIATRICS

Consent for Treatment of a Minor Without a Parent or Legal Guardian Present

Patient Name: _____ Date: _____

Patient Date of Birth: _____

Minors aged 16 or older unaccompanied by a parent or legal guardian for Allergy Shots:

_____ In the event that I am unable to personally accompany my child to Piedmont Pediatrics for their allergy shots, I give my permission for the allergy shots to be administered without my presence or the presence of another accompanying adult in the building. I also consent to any treatment that might need to be given due to complications or adverse reactions that could occur from receiving the allergy shots.

_____
Printed Name of Parent/Legal Guardian

_____
Signature of Parent/ Legal Guardian

_____ _____
Witness Signature Date