

I GIVE MY PERMISSION TO THE STAFF OF GRAND TRAVERSE ALLERGY,
P.C., UNDER THE DOCTOR'S/PROVIDER'S SUPERVISION, TO TREAT:

NAME OF PATIENT

DATE OF BIRTH

A MINOR, WHILE HE/SHE IS AT HIS/HER APPOINTMENT WITHOUT MY
PRESENCE. GRAND TRAVERSE ALLERGY, P.C. ALSO HAS MY PERMISSION
TO TRANSPORT MY MINOR CHILD TO THE CLOSEST HOSPITAL OR
MEDICAL FACILITY FOR TREATMENT IF THEY FIND THAT IT IS
NECESSARY FOR ANY REASON DURING THIS TIME.

PARENT/GUARDIAN SIGNATURE

RELATIONSHIP TO PATIENT

DATE

PERMISSION VALID INDEFFINATELY UNLESS REVOKED BY PARENT OR
GUARDIAN