

ALLERGY ASSOCIATES OF WESTERN MICHIGAN, P.C.

Richard R. Townley, M.D.

Thomas P. Miller, M.D.

Erin J. Gibson, PA-C

I, (print name) _____, give my consent to Allergy Associates of Western Michigan, P.C. to give my minor child allergy injections in my absence.

In the event of a reaction, I give my consent for any treatment deemed necessary and appropriate for my child.

Name of Patient (please print) _____

Patient date of birth _____

Signature of Parent/Guardian _____

Date _____

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