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Authorization for Allergy Shot for a Minor Child

This form, "Authorization for Allergy Shot for a Minor Child" is completed by a parent or court-appointed legal guardian who will be unavailable at the time of their child's appointment for an allergy shot and wants to authorize ENT Medical Services to provide the allergy shot in their absence.

I hereby authorize ENT Medical Services to provide allergy shots to my minor child listed below, during my absence. I understand and agree that my child must remain at the office for twenty minutes after each shot. I understand and agree that if my child suffers an allergic reaction, ENT Medical Services may call 911 and my child may be transported to a hospital for treatment, if necessary.

Child's Full Name: _____ Date of birth: _____

Signature of Parent/Court-Appointed Guardian

Date

Printed Name of Parent/Court-Appointed Guardian

Telephone # (in case of emergency)