GEIST CENTER FOR ALLERGY, ASTHMA IMMUNOLOGY, PC
8150 OAKLANDON ROAD, SUITE 119 INDIANAPOLIS, INDIANA 46236
TEL (317)826.5440 FAX (317)826.5463 WWW.GEISTALLERGY.COM

PARENT CONSENT FORM

PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

PARTICIPANT'S NAME: _____

BIRTH DATE: _____ SEX: _____

PARENT/GUARDIAN'S NAME: _____

HOME ADDRESS: _____

PHONE: _____

EMERGENCY MEDICAL TREATMENT:

In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers listed, contact:

NAME & RELATIONSHIP: _____ PHONE: _____

FAMILY DOCTOR: _____ PHONE: _____

INSURANCE CARRIER: _____ POLICY # _____

SIGNATURE: _____ DATE: _____

Permission to Bring (and/or) Give Permission for Treatment

I, (name of parent or guardian) _____, grant permission for my child (name of child) _____ to be treated by Geist Center for Allergy, Asthma & Immunology, PC, located at 8150 Oaklandon Road Suite 119, Indianapolis, IN 46236. I also designate the following person or persons listed below to bring my child to the office to discuss medical treatment and issues. They can also receive prescriptions from the doctor or staff in my absence.

NAME & RELATIONSHIP TO PATIENT: _____ DATE: _____ PHONE # _____

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