Dearborn Allergy & Asthma Clinic, P.C.
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313-565-3565
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Diane L. Baranowski, MD

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PERMISSION TO TREAT RELEASE FORM

Date: ________________________________

I give **DEARBORN ALLERGY & ASTHMA CLINIC, P.C.** and its employees, permission to treat my son/daughter:

____ in my absence. I also understand that they will not be given any treatment unless accompanied by a parent/guardian age 18 or older.

Signed: ____

Relationship: ____

Witness: ____

Number to call in an emergency: ______________________________________