Dearborn Allergy & Asthma Clinic, P.C.
20200 Outer Drive
Dearborn MI 48124
313-565-3565
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James G. Fordyce, MD

Diane L. Baranowski, MD

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: _____