MID-KANSAS PEDIATRIC ASSOCIATES, P.A.
www.midkspeds.com

EAST OFFICE
9825 Shannon Woods
Wichita, Kansas 67226
(316) 634-2000
Fax (316) 634-2321

WEST OFFICE
6837 W. 37th Street North, Bldg. 1
Wichita, Kansas 67205
(316) 773-3100
Fax (316) 773-3777

DERBY OFFICE
201 N. Georgie
Derby, Kansas 67037
(316) 719-2001
Fax (316) 719-2020

Consent to treat a minor when Parents/Guardians are not present for Allergy Immunotherapy and reactions

The undersigned parent/guardians(s) of _____DOB:_____, a minor, authorizes treatment, including allergy injections, or any urgent, or emergent services that may be necessary by physicians and/or staff at Mid-Kansas Pediatric Associates, P.A.

The possible risks, hazards, and complications from the treatment, or procedure have been explained to me and I authorize physicians and/or staff at Mid-Kansas Pediatric Associates, P.A. to administer allergy injections. Risks include, but are not limited to the following:

Systemic reaction: mild, moderate, severe – ranging from simple hives to frank anaphylaxis, the latter can be fatal. This is most predominant during the first 30 minutes following allergy injection; throughout the entire course of therapy.

*Should anaphylaxis occur, the parent/guardian agrees to come to Mid-Kansas Pediatric Associates, P.A. immediately when contacted.

Persons to contact in an emergency:

1. _____ Phone: _____
2. _____ Phone: _____

Known drug allergies: _____

Parent/Guardian(s) information:

Father's Name:	Mother's Name:
Home phone:	Home Phone:
Work phone:	Work phone:
Cell phone:	Cell phone:

Signature: _____ Date: _____

This consent shall remain effective until written revocation, signed by the minor's parent/guardian, and received by Mid-Kansas Pediatric Associates, P.A.