South Georgia
Pediatric & Allergy Center P.C.
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Alan J. Alvarado, M.D.
Board Certified Pediatrics
Board Certified Allergy & Immunology

Robert J. Criscuola, M.D.
Board Certified Pediatrics

Allergy and Immunotherapy Consent

Date: _____

Patient Name:_____ DOB:_____

Dear Doctor _____,

_____ will receive his/her Immunotherapy (allergy) injections in your office. Our office policy requires the patient to remain in the medical facility for a minimum of twenty (20) minutes after injections are given and that a physician be present during the waiting period. We are requesting that the supervising physician sign this form and return to our office as Immunotherapy injection consent. We appreciate your assistance and cooperation.

Sincerely,

Dr. Alan J. Alvarado, MD

I have received the above statement and hereby give permission for the above named patient to receive his/her immunotherapy injections in my office under my supervision.

By signing this form I, Dr. _____, release Dr. Alan J. Alvarado, MD from any and all responsibility if the immunotherapy injections are not given under the presence of the physician stated above.

_____ _____

Patient's Signature Physician's Signature

Physician's Name: _____

Address: _____

_____

Phone:_____ Fax:_____