ALLERGY ASSOCIATES of Western Michigan PC

Thomas P. Miller, M.D. Erica Palmisano, M.D.
Erin J. Gibson, PA-C

I, (print name)_____, give my consent to Allergy Associates of Western Michigan, P.C. to give my minor child allergy injections in my absence.

In the event of a reaction, I give my consent for any treatment deemed necessary and appropriate for my child.

Name of Patient (please print)_____
Patient date of birth_____
Signature of Parent/Guardian_____
Date_____

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