# Allergist Letter of Consent for Treatment

# Informed Consent to Administer Allergy Injections:

**Date:** Click or tap here to enter text.

**Patient Name:** Click or tap here to enter text.

**Patient DOB:** Click or tap here to enter text.

**Patient N#:** Click or tap here to enter text.

The above named patient is currently under my care and is receiving allergy immunotherapy. I authorize UNF Student Health Services to administer allergy injections as indicated on our record and order sheet. The patient will continue to follow-up with me as directed, as well as obtain allergy serum from our clinic.

Click or tap here to enter text.  
MD Signature

Click or tap here to enter text.

Printed name of MD

Affix Clinic Address stamp below: