

Lisa Sullivan, M.D.
Angela Oest, MPH, P.A.-C
Kathleen Finneke, P.A.-C

Specializing in Pediatric and Adult Allergy, Asthma and Immunology

Consent to Treat a Minor Child

I hereby authorize Dr. Sullivan, or associate to treat my son/daughter as necessary.

Name of Child: _____

Dated at: _____ City/State

this _____ day of _____ 2009.

Signed: _____
(Parent/Guardian)

Witnessed: _____

