

Copperfield Allergy and Asthma Center & Katy Prairie Allergy and Asthma Center

Offices of Douglas K. Schreiber, M.D.

Certified by American Board of Internal Medicine and American Board of Allergy and Immunology

Power of Attorney For Medical Decisions

I, _____, parent/legal guardian of

_____ **give my permission for Dr. Douglas K. Schreiber and/or associates to administer treatment and/or allergy injections to my child in my absence while under the care of the persons listed below.** I fully understand the possible risks to the health and/or life of my minor child associated with receiving treatment and/or allergy injections. I have also informed the persons listed below of how to recognize and respond to a systemic or anaphylactic reaction and they have accepted the responsibility of monitoring my child after he/she has received their allergy injection.

	Reaction Warning Person Initial	Signs Reviewed Nurse Initial
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Knowing these risks and being of legal age and of sound mind, I willingly assume all responsibility which may result from my decision to not be present with my minor child at the time he/she receives the treatment and/or allergy injections.

I give Copperfield Allergy and Asthma Center/Katy Prairie Allergy and Asthma Center, Dr. Douglas K. Schreiber and/or associates Power of Attorney for medical decisions to treat my minor child in the case of any adverse reaction resulting from treatment and/or allergy injections received.

Signed: _____ Date: _____
(Patient / Parent / Legal Guardian)

Emergency contact: _____ Phone Number: _____

Witnessed by: _____ Date: _____

CAAC/KPAAC 08/22/07