AFFILIATED DERMATOLOGISTS

Consent for Medical Treatment of a Minor Child

*****Parent or Legal Guardian MUST accompany minor on first visits*****

Date: _____

Patient Name: _____

Patient Birthdate: _____

Appointment Date: _____

I hereby give Affiliated Dermatologists consent for any medical treatment that may be required for my child during my absence at their appointment.

Parent or Legal Guardian's Telephone Number: _____

Parent or Legal Guardian's Signature: _____

Printed name of Parent or Legal Guardian: _____