

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: