Medical Dermatology Specialists

MDS

MINOR/CHILD CONSENT

Patient Name: _____ Date of Birth: _____

Parent/Legal Guardian Names:

_____ Date of Birth: _____ Phone #: _____

_____ Date of Birth: _____ Phone #: _____

The following persons have my permission to authorize medical treatment if the parents listed above are not present in the office to give consent. I understand that it is my responsibility to notify Medical Dermatology Specialists if there are any changes to the list below.

1. Name: _____ Date of Birth: _____

   Relationship: _____ Phone #: _____

2. Name: _____ Date of Birth: _____

   Relationship: _____ Phone #: _____

Medical Dermatology Specialists will not bill a responsible party with a different last name or address than the patient's, unless that person is present to sign this sheet.

If the adult accompanying the minor is not the parent of the minor child then our office requires a copy of the legal documentation indicating guardianship of the minor child.

The adult accompanying the minor child must sign his/her name as the responsible party. By signing below you hereby authorize all the dermatological treatment, deemed necessary by the dermatologist, for the patient: _____.

Name of Responsible Party: _____

Address of Responsible Party: _____

Signature of Responsible Party: _____

Relationship of Responsible Party to Patient: _____

Date: _____