



CONSENT FOR TREATMENT OF MINOR

Minor Patient Name: _____ Date of Birth: _____

I hereby give permission for the following people to make decisions regarding the treatment of my child including, but not limited to, examinations, injections and/or procedures. I understand those listed below will have the authority to authorize treatment.

Name

Relationship to patient

Name

Relationship to patient

Name

Relationship to patient

Name

Relationship to patient

This authorization will remain in effect unless so designated in writing that such consent for treatment of minor is cancelled. I will notify Water's Edge Dermatology of any changes as to the health status of my child.

Name of Parent or Guardian

Relationship to patient

Signature of Parent or Guardian

Date