Affiliated Dermatology
Experts in Skin Disease Treatment & Prevention

CONSENT for MEDICAL TREATMENT of a MINOR CHILD

I herby authorize_____to give consent for all medical/surgical

treatments that may be required for my child

_____

during my absence to Affiliated Dermatology®.

Child's Full Name: _____

Date of Birth:_____

Child's Allergies: _____

Current Medication Child is taking:_____

_____

Parent or Legal Guardian's Telephone number:_____

Parent or Legal Guardian's Signature on File:_____

****Photo ID with signature must accompany signed consent of Parent or Legal Guardian****

Parent or Legal Documented Guardian MUST Accompany Minor On First Visits**