Treatment of Minors

Patient Name: _____Date of Birth_____

Thank you for entrusting the dermatology care of your child to our practice. From time to time there are situations in which a parent/guardian cannot attend the appointment with their child. **Please choose the most suitable option(s) below that meets your wishes for the care of your minor patient, in the event you are not present:**

☐ As the parent/guardian of the above stated patient, **I allow the minor (16+) to attend appointments without my physical presence**. I understand this authorization is valid unless otherwise revoked. I acknowledge that all surgical appointments would require the physical presence of a parent/guardian. The minor may consent to participation in the routine office exam, receipt of prescriptions, and minor procedures (such as wart removal, simple excisions, etc.). I understand there may be instances in which the provider chooses to schedule the necessary treatment at a future date if my physical presence is deemed to be necessary.

OR

☐ As the parent/guardian of the above stated patient, my child may attend appointments without me (legal guardian), however they may **NOT** attend alone. **My child may attend the appointment with the individuals below, and the adult may consent to treatment on my behalf**. This treatment includes routine office exam, receipt of prescriptions, and minor procedures (such as wart removal, simple excisions, etc.) and may also consent to surgical procedures within the office.

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

The above treatment plan will remain in effect unless otherwise revoked and/or until the child turns 18. I understand that the Guarantor is financially responsible for any treatment provided.

Signature: _____ **Phone Number**: (_____)_____

Relationship: _____ **Today's Date**: _____