A to Z Dermatology

Consent of Medical Treatment of a Minor Child

PARENT OR LEGAL GUARDIAN DOCUMENTED GUARDIAN MUST ACCOMPANY MINOR ON VISIT(S).

I hereby authorize _____ to give consent for all treatments that may be required for my child during my absence to A to Z Dermatology.

Child's Full Name: _____

Date of Birth: _____

Child's Allergies: _____

Current Medication: _____

_____

Parent or Legal Guardian's Phone Number: _____

Parent or Legal Guardian's Signature: _____

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