CENTER FOR ADVANCED DERMATOLOGY

Consent to Treatment of Minors

Patient Name: ___________________________________ Date of Birth: _____________________

Many times parents/guardians find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany you child.

I hereby grant the providers (doctors, physician assistants, or aestheticians) at the Center for Advanced Dermatology permission to treat my child when they arrive at the office unaccompanied. This includes all treatments except for (please list any treatment/procedures a parent/guardian must accompany the minor):

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Parent/Guardian: _____________________________________
Please Print Name

_____________________________________ Date: _______________
Signature