Dermatology & Skin Surgery Center

Dermatology & Skin Surgery Center, PC - 210 Village Center Pkwy - Stockbridge, GA 30281

PERMISSION TO ACCOMPANY A MINOR

I, _____ give permission to the adult(s) listed below to accompany my child (name and DOB) _____ and authorize treatment for my child in accordance with the office policy of **Dermatology & Skin Surgery Center, PC.** This includes bringing the child into the office of **Dermatology & Skin Surgery Center, PC,** providing a history of present illness, disclosure of protected health information, accompanying consented research study procedures, and witnessing any physical exam completed by the provider. This adult has the responsibility to relay and diagnosis, treatment plan and/or prescriptions(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays and coinsurance.

This authorization is effective on: _____ and expires _____.

Name: _____

Name: _____

Name: _____

Child's Health Information:

Current prescribed or over the counter medications and dosages:

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Allergies, illnesses or other comments: _____

_____

Emergency Contact Information for Parents/Guardians:

Where/how can you be reached in case of emergency? Phone _____

Comments _____

Temporary Guardian Information Name: _____

Phone: _____ Address: _____

_____ _____

Parent or Legal Guardian's Signature ***Date***