Dermatology & Skin Surgery Center

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

PERMISSION TO TREAT A MINOR

I, _____, parent or legal guardian of _____, born the _____ day of _____, 20_____ do hereby consent my child to attend his/her appointment alone without my presence and authorize treatment in accordance with the office policy of **Dermatology & Skin Surgery Center, PC**. This includes providing a history of present illness, disclosure of protected health information, and responsibility for relaying any diagnosis, treatment plan, or prescription(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 on: _____.

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***