Consent to Treat Minor Patients

For non-emancipated minors less than 18 years old

By signing this form I acknowledge that I am the parent/legal guardian of:

____ _____/_____/_____
(Child's name) (Date of Birth)

and I agree to allow my child to receive medical care in The Skin Surgery Center offices. This consent applies to routine medical care including, but not limited to, physical exams, routine testing, office treatments, standard vaccinations, and any counseling related to the visit. I understand that no interventions or treatment will be performed without attempts to discuss with a parent/guardian first. Phone number of parent/guardian:____
Exceptions to this would be the need for any emergent/urgent medical care.

In my absence I will allow the following individuals to act on my behalf and give consent for any medical treatment my child may require:

(Names of people who can act on my behalf) PLEASE PRINT LEGIBLY

1. ____________________________ Phone #_______________ Relationship_______________

2. ____________________________ Phone #_______________ Relationship_______________

I consent to my child being seen by a provider of The Skin Surgery Center unaccompanied by a parent/legal guardian or above listed adult. ____ Yes ____No

Limitations on the time frame for this authorization: □ none □ date ________________
or on the date child reaches the age of majority. I understand that I have the right to revoke this authorization, in writing, at any time.
(Requests to revoke an authorization must be directed to the attention of The Skin Surgery Center Practice Administrator).

I agree with the information contained above and give consent for treatment of my minor child.

Parent of Guardian Printed Name: ____

Relationship to Patient: ____

Signature: ____ Date:_________________________