SKIN P.C.
DERMATOLOGY CENTER
ELKHORN | FREMONT | WAHOO | COLUMBUS
www.skinpc.com

Authorization to Treat Minor Patient

(Parent or guardian must attend 1st appointment of new patient)

I, _____ , parent or legal guardian of

_____

(Patient Name) (Date of Birth)

authorize Skin P.C. to evaluate and treat my child for any common skin condition such as acne, warts, rash, eczema, or psoriasis.

The provider (physician, physician assistant, nurse practitioner) has fully explained, in terms clear to me, the effects and nature of the procedure(s) to be performed, foreseeable risks involved, and alternative methods of treatment. I have been given the opportunity to ask any questions regarding this procedure and these questions have been answered to my satisfaction.

This consent will be good for one year from the date of signing.

I also give the following individuals permission to bring my child to their appointment:

1. _____
   (Name) (Relationship)
2. _____
   (Name) (Relationship)
3. _____
   (Name) (Relationship)

Patient/Legal Guardian (Signature) _____ Date: _____

Witness:_____ Date:_____

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