THE SKIN WELLNESS CENTER

Consent for the Treatment of a Minor

Child's Name: ____ Chart #: ______________________

I, the undersigned parent or legal guardian, authorize the person(s) listed below to consent to the treatment of my child, including, but not limited to, emergency, anesthetic, or surgical services when I am not immediately available in person.

- It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.
- I understand that my child's copay or other fees are due at the time of service and the person accompanying him/her to the appointment is responsible for paying any copay or out-of-pocket expense.

______ My child is able to drive him/herself to appointments and may come alone. He/she is permitted to consent to any medical treatment.

Person(s) who may consent to treatment (please print):

Name: ________________________________ Relationship to child: ______________ Phone: ______________

Name: ________________________________ Relationship to child: ______________ Phone: ______________

Name: ________________________________ Relationship to child: ______________ Phone: ______________

Important medical information

Medical concerns: ____

Known allergies: ____

Anything else we should know related to your child's health: ________________________________

____

Parent/guardian information

Name of parent or legal guardian: ____

Relationship to child: _____ Mother _____ Father _____ Court-appointed guardian

Contact number(s): ____

Address: ____ City, State, Zip: ____________________________

Signature: ________________________________ Date: _______________

This consent is effective until the child turns 18 or until withdrawn in writing by the child's parent or guardian.