THE SKIN WELLNESS CENTER

Patient Name _____ Date _____ Patient # _____

Parental Consent for Treatment of a Minor Child

At the first appointment, patients under the age of 18 must be accompanied by a parent or legal guardian, no exceptions. Grandparents cannot represent the parent or legal guardian.

For families who are ongoing patients of The Skin Wellness Center, it may be more convenient to have prior authorization for medical care delivered to minors without a parent having to be present during treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

Authorization

I (we) request and authorize The Skin Wellness Center and its personnel to deliver medical care to my (our) child listed below:

Please try to contact me (us) regarding the healthcare of my (our) child at the following number(s):

Parent's name: _____

Phone (office/home): _____

Parent's name: _____

Phone (office/home): _____

Other (relationship): _____

Phone (office/home): _____

_____ _____ _____

Signature of Patient or Patient's Representative Relation to Patient Date

NOTE: *If any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no parent, etc.) is in place, please explain in the space below with your signature, printed name, and a phone number at which you can be contacted.*

_____

_____

_____

_____ _____ _____

Signature of Patient or Patient's Representative Relation to Patient Date

Return signed to **Fax**: 865.896.9117 | **Email**: patientservices@swcknox.com