

REN Dermatology & LASER CENTER

Authorization for Consent to Medical Treatment of Minor Child

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/Guardian is not present.

REN Dermatology will require a NEW MINOR CONSENT on file to be signed every calendar year for treatment of all medical visits or cosmetic services.

Child's Full Name: _____

Date of Birth: _____ / _____ / _____

Child may be seen in office for any medical or cosmetic appointments **WITHOUT** a Parent/Guardian or additional adult present: **Yes:** _____ **No:** _____

I, _____, hereby authorize, _____, to be seen
(Parent/Guardian) (child's name)
at REN Dermatology without a Parent and/or Guardian present for any **medical or cosmetic** visits.

Person(s) who may be present with child for medical/cosmetic appointments (**must be older than 18**):
(please print)

Name: _____ Relationship to Child: _____ Phone: (____) _____ - _____

Name: _____ Relationship to Child: _____ Phone: (____) _____ - _____

Parent/Guardian Phone #: (____) _____ - _____ **Name:** _____ **Relationship:** _____

Additional Phone #: (____) _____ - _____ **Name:** _____ **Relationship:** _____

(other parent/guardian cell- if main # is not available)

Emergency Contact # (other than Parent/Guardian):(____) _____ - _____ **Additional #:** (____) _____ - _____
(home) (Cell)

Any allergies child may have or important medical history that may be needed while Parent/Guardian is not present at his/her appointment: _____

Signature of Parent/Guardian(s): _____

Date signed: _____ / _____ / _____

This Consent is effective until withdrawn in writing by the child's Parent/Guardian.