

# REN Dermatology & LASER CENTER

## Authorization for Consent to Medical Treatment of Minor

### PATIENT INFORMATION

Patient's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

The minor patient listed above **MAY** be seen in office for medical and/or cosmetic appointments **WITHOUT** a parent, legal guardian, or chaperone present.

The minor patient listed above may **NOT** be seen in office for medical and/or cosmetic appointments without a parent, legal guardian, or chaperone present.

### PATIENT ALLERGIES

Please list patient's allergies, significant medical history, and medical conditions here:

\_\_\_\_\_  
\_\_\_\_\_

### CHAPERONE

Person(s) who may be present with minor for medical/cosmetic appointments when a parent or legal guardian is unavailable (*must be older than 18*):

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### EMERGENCY CONTACT

Person(s) to contact when parent or legal guardian is not available.

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship to Minor: \_\_\_\_\_

Additional- if unable to reach above:

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship to Minor: \_\_\_\_\_

### AUTHORIZATION

Print Name(Parent/Guardian): \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Signature (Parent/Guardian): \_\_\_\_\_ Today's Date: \_\_\_\_\_

*This release will expire 12 months after signature date. Release will remain in effect for 12 months OR until terminated by me (child's parent/guardian) in writing.*