REN
DERMATOLOGY
AND AESTHETICS

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.