REN

DERMATOLOGY

# 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.***