

**CONSENT TO TREAT MINORS**

Minor children must be accompanied by a custodial parent or legal guardian for their initial visit. Minor children may be seen on **subsequent** visits with an authorized note, as long as they are not being seen for a procedure requiring custodial parent/legal guardian’s signature for consent.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize any medical provider at West Dermatology to see and treat my son/daughter, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, without my presence.

I certify that I am the custodial parent/legal guardian.

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Name (Print) of custodial parent/legal guardian** |  | **Signature of custodial parent/legal guardian** |

**Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Office Use Only)**

Office Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MRN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_