CONSENT TO TREAT A MINOR

Patient Name: _____ DOB: _____

Parent/Guardian: _____ DOB: _____

The following statement was read by the parent/guardian listed above:

I give written permission for Valley Dermatology, LLC and its representative physician to make medical decisions/treat my child since I, the parent/legal guardian listed above may not be present at all of his/her scheduled follow up visits.

I understand that I or another parent/legal guardian must be present for my child's first appointment. If special circumstances are warranted, a parent or legal guardian must be available by phone during the minors' appointment at the listed number_____.

I give permission to the following listed adults to accompany my child and authorize treatment for my child's subsequent visits in accordance with Valley Dermatology, LLC's office policy:

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

This includes bringing the child into Valley Dermatology, LLC, providing a history of present illness, disclosing protected health information, accompanying consented research study procedures, and witnessing any physical examination completed by the provider. This adult has the responsibility to relay any diagnosis, treatment plan or prescription(s) to the parent or legal guardian named above. I agree to be available by phone and to be financially responsible for all copays and coinsurance.

I also understand this signed consent will be valid until the minor child is 18 years of age, or unless I withdraw this permission in writing.

I certify that I understand and agree to the foregoing permission statement.

Signature: _____ Date:_____