Dermatology Center of Lake Orion

Treatment Consent For Minors

Date:______/______/________

I, ______________________________, give permission for my child,________________________, to be evaluated and treated by the provider and staff at Dermatology Center of Lake Orion. I do not need to be present during the visit dated above.

Name of person(s) allowed to bring my child in for treatment…

NAME	RELATIONSHIP
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Signature of Parent:________________________________ ________/________/______________
Signature Date

***Please provide a telephone number where you can be reached if the provider or staff needs to speak with you during your child's appointment.**

(____)_____-__________

***If you would like this consent to be in effect for one (1) year from the date indicated above, please sign and date below.**

Staff Signature and Date: ______________________________ ________/________/____________

Staff Signature and Date: ______________________________ ________/________/____________
Signature Date

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