CONSENT TO TREAT A MINOR

Minor Patient Name: _____ **Date of Birth:** _____

In the event of my absence, I hereby give my permission for the following individuals to make decisions regarding the treatment of my child, including, but not limited to, examinations, injections and/or procedures. I understand those listed below will have the authority to authorize treatment.

_____

Name **Relationship to Patient**

_____

Name **Relationship to Patient**

I understand this signed consent will be valid until the minor child is 18 years of age, or unless so designated in writing that such consent for treatment of minor is cancelled. I will notify Front Range Dermatology Associates of any changes as to the health status of my child. I will be available by telephone should any questions arise.

_____

Name of Parent or Guardian **Telephone Number**

_____

Signature of Parent or Guardian **Date**