Affiliated Dermatology
Experts in Skin Disease Treatment & Prevention

Consent for Medical Treatment of a Minor Child

I herby authorize (Chaperone's Name)_____to give consent for all medical/surgical treatments that may be required for my child during my absence at Affiliated Dermatology®.

☐ Check this box if patient is on Accutane therapy (Patients 15 years and older can be seen without parent/guardian for follow up visits)

☐ Check this box if patient is being seen for an acne visit (Patients 15 years and older can be seen without parent/guardian for follow up visits)

Please note that we will not make any changes to patient's treatment/medications without a parent or legal guardian present during office visit. If changes are necessary, parent or legal guardian will need to be present at patient's follow up visit.

Child's Full Name:_____

Date of Birth:_____

Child's Allergies:_____

Current Medication Child is taking:_____

Parent or Legal Guardian's Telephone Number:_____

Parent or Legal Guardian's Signature on File:_____ Date:_____

(Signature on file is valid for one year, must renew yearly)

Photo ID with signature must accompany signed consent of Parent or Legal Guardian

****Parent or Legal Guardian MUST accompany minor on first visit at Affiliated Dermatology®****