



## Permission to Treat Unaccompanied Minor

### Patient Information

Last Name	First Name	D.O.B.	
Address	City	State	Zip

### Parent or Guardian Information

Last Name	First Name	Relation to Patient	
Address	City	State	Zip

### Consent

My signature below gives my permission for the physicians and/or staff of Derick Dermatology to treat my minor child.

I understand that appropriate treatment may include (but may not be limited to) any or all of the following:

- Examination
- Advice
- Prescribing of medication
- Laboratory workup
- Biopsy
- Destruction of lesions
- Excision

I will be available on the date of treatment and can be reached at the following phone numbers:

- Work Phone Number: \_\_\_\_\_
- Home Phone Number: \_\_\_\_\_
- Cell Phone Number: \_\_\_\_\_

This permission to treat is valid until it is revoked in writing.

Parent or Guardian Signature

Date